PRINTED: 07/16/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		495226	B. WING _		06/0	;)7/2019
	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
E 000	survey was conduct	mergency Preparedness ed 6/4/19 through 6/7/19.	E 0	00		
E 036 SS=D	CFR Part 483.73, Rocare Facilities. One during the survey.	uired for compliance with 42 equirement for Long-Term e complaint was investigated ting	E 0	36	-	7/21/19
	develop and maintain preparedness training based on the emerging paragraph (a) of this paragraph (a)(1) of the procedures at paragraph the communication paragraph. The training be reviewed and upon	ing. The [facility] must in an emergency and testing program that is ency plan set forth in a section, risk assessment at this section, policies and traph (b) of this section, and plan at paragraph (c) of this g and testing program must dated at least annually.				
	testing. The ICF/IID an emergency prepared program that is based forth in paragraph (a assessment at paragraphicies and procedus section, and the comparagraph (c) of this testing program must least annually. The I	must develop and maintain aredness training and testing ed on the emergency plan set a) of this section, risk graph (a)(1) of this section, ures at paragraph (b) of this				
		s at §494.62(d):] Training, ion. The dialysis facility must in an emergency				
ABORATORY	DIRECTOR'S OR PROVIDER	V/SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE

Electronically Signed 07/08/2019

Facility ID: VA0050

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRI IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B. WING		C 06/07/2019	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/07/2019	
				730 LUNENBURG HIGHW		
WAYLAND NURSING AND REHABILITATION CENTER				KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
E 036	section, risk assessme this section, policies at (b) of this section, and paragraph (c) of this section and orientation prograupdated at least annual This REQUIREMENT by: Based on staff intervive review it was determined to have a compute preparedness plan. The facility staff failed that the facility has a program that meets the regulation and document and testing program hupdated on, at least at the findings include: An interview was contained and interview was contained and interview staff in administrator, regardinal contained the section and testing program hupdated on, at least at the findings include:	g, testing and patient hat is based on the borth in paragraph (a) of this hent at paragraph (a)(1) of hand procedures at paragraph d the communication plan at hection. The training, testing ham must be reviewed and hally. The is not met as evidenced hiew and facility document hed that the facility staff helete emergency If to evidence documentation havritten training and testing he requirements of the hentation that the training has been reviewed and han annual basis. Inducted with ASM hember) #1, the	E 03		nd ts. s a of ent ny ing	
	and any updates com ASM #1 informed this have documentation t	and review of the program upleted on an annual basis. It is surveyor that they did not that the training and testing viewed and updated on an		this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. E-36		
	ASM #1, the administ of nursing, and ASM	rator, ASM #2, the director #4, the facility nurse le aware of the above		The emergency Preparedness Plan was updated and completed to include train and testing and was reviewed and approved.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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		495226	B. WING_			06/	07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 80 LUNENBURG HIGHW EYSVILLE, VA 23947		
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E 036	concerns on 6/6/19 at			036	Staff will maintain evidence of testing ir log book and the log will be updated as necessary. Evidence of training and testing of the I will be submitted to the Safety Committ of the facility for compliance and prope documentation. Minutes of the Safety Committee will be submitted to the facility SQAPI committee for review and suggestions.	ΞΡ ee r	
E 037 SS=C	(1) Training program. The [facility, except CAHs,		E (037			7/21/19
	ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training.						

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		495226	B. WING		06/0: C	7/2019	
	ROVIDER OR SUPPLIER D NURSING AND REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	1 00/0	772013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
E 037	*[For Hospices at §4 hospice must do all of (i) Initial training in elepolicies and procedures and procedures are expected roles. (ii) Demonstrate staff procedures. (iii) Provide emergent least annually. (iv) Periodically reviet emergency prepared employees (including special emphasis pla procedures necessation others. *[For PRTFs at §441 program. The PRTF (i) Initial training in elepolicies and procedustaff, individuals provarrangement, and voexpected roles. (ii) After initial training preparedness training (iii) Demonstrate staff procedures. (iv) Maintain docume preparedness training training	If knowledge of emergency 18.113(d):] (1) Training. The of the following: mergency preparedness res to all new and existing and individuals providing gement, consistent with their f knowledge of emergency cy preparedness training at w and rehearse its ness plan with hospice g nonemployee staff), with need on carrying out the ry to protect patients and .184(d):] (1) Training must do all of the following: mergency preparedness res to all new and existing viding services under lunteers, consistent with their g, provide emergency g at least annually. If knowledge of emergency entation of all emergency g. 84(d):] (1) The PACE	EOS	37			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495226	B. WING _			C 06/07/2019	
	NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODI 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	•	00/07/2013	
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E 037	Continued From page	ge 4	E	037			
	policies and proced staff, individuals pro arrangement, contra volunteers, consiste (ii) Provide emerger least annually. (iii) Demonstrate sta procedures, includir what to do, where to case of an emerger (iv) Maintain docum *[For CORFs at §48 CORF must do all control (i) Provide initial transpreparedness policies and existing staff, in under arrangement, with their expected (ii) Provide emerger least annually. (iii) Maintain docum (iv) Demonstrate sta procedures. All new and assigned specific the CORF's emerger their first workday. Include instruction in alarm systems and equipment. *[For CAHs at §485 The CAH must do at (i) Initial training in expolicies and proced reporting and exting and where necessal.	ures to all new and existing oviding on-site services under actors, participants, and ent with their expected roles. Incy preparedness training at aff knowledge of emergencying informing participants of o go, and whom to contact in acy. Incentation of all training. 85.68(d):](1) Training. The offithe following: ining in emergencying es and procedures to all new addividuals providing services and volunteers, consistent aroles. Incy preparedness training at entation of the training. In emergency of personnel must be oriented fic responsibilities regarding ency plan within 2 weeks of the training program must in the location and use of signals and firefighting in the location and use of signals and the location and use of signals and the					

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	495226		B. WING _	B. WING		C 06/07/2019	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>'</u>	00/01/2013	
WAVI AND	NURSING AND REHAB	II ITATION CENTED		730 LUNENBURG HIGHW			
WAILANL	NORSING AND REHAB	ILITATION CENTER		KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION (CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		NC
E 037	Continued From page	∍ 5	E	037			
	and volunteers, consiroles. (ii) Provide emergence least annually. (iii) Maintain documer (iv) Demonstrate staff procedures. *[For CMHCs at §485 CMHC must provide preparedness policies and existing staff, indunder arrangement, a with their expected rodocumentation of the demonstrate staff known in the constrate staff known in the	and existing staff, services under arrangement, istent with their expected by preparedness training at intation of the training. If knowledge of emergency is and procedures to all new ividuals providing services and volunteers, consistent of the company of the company in training. The CMHC must owledge of emergency er, the CMHC must provide					
	by: Based on staff interv review it was determi failed to have a comp preparedness plan. The facility staff failed of the facility's initial e training and annual e training offerings and	I to evidence documentation emergency preparedness mergency preparedness documentation that facility itial & annual emergency		E-37 Staff will receive training and ir on the facility s Emergency preparedness training. Documnew hires initial training will be SDC office. The administrator or his design conduct annual training session to educate them on the Emergand any updates that may have Proof of annual in-service train EP will be kept in the SDC office Submitted to the facility Safety for review and compliance.	nentation where will one will one with stancy Plare occurre one on the ce and	of ne aff n d.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495226	B. WING	B. WING		C 06/07/2019	
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		0/01/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
E 037	asked for the facility's preparedness training preparedness training documentation that fainitial & annual emergy ASM #1 stated the fadocumentation of the preparedness training preparedness training get the information in training has not been ASM #1, the administ of nursing, and ASM sconsultant, were mad concerns on 6/6/19 a INITIAL COMMENTS An unannounced Mesurvey was conducte 6/7/19. Complaints we survey. Corrections a with the following 42 for the information in training has not been as a survey was conducted to the information in the information in training has not been as a survey was conducted to the information in the information in training has not been as a survey was conducted to the information in the information	ducted with ASM nember) #1, the 19 at 6:47 p.m. ASM #1 was initial emergency g and annual emergency g offerings and icility staff have received gency preparedness training. icility did not have initial emergency g and the annual emergency g and the annual emergency g. He stated the employees orientation but the annual completed. rator, ASM #2, the director #4, the facility nurse e aware of the above to 7:35 p.m. dicare/Medicaid standard d from 6/4/19 through were investigated during this are required for compliance CFR Part 483 of the Federal irements. The life safety	F 0	The meetings of the Safety or well as proof of annual and in in-service training on the EP is submitted to the QAPI Comm review and compliance.	itial vill be		
F 550 SS=D	at the time of the surviconsisted of 27 currel records. Resident Rights/Exer CFR(s): 483.10(a)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	(2)(b)(1)(2)	F 5	50		7/21/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495226	B. WING_	B. WING		C 06/07/2019	
	ROVIDER OR SUPPLIER NURSING AND REHA	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 550	access to persons a outside the facility, this section. §483.10(a)(1) A fact with respect and digresident in a manner promotes maintenather quality of life, reindividuality. The fapromote the rights of \$483.10(a)(2) The faccess to quality caseverity of condition must establish and practices regarding provision of service residents regardles. §483.10(b) Exercise The resident has the rights as a resident or resident can exercise interference, coerci	and communication with and and services inside and including those specified in illity must treat each resident gnity and care for each er and in an environment that nice or enhancement of his or ecognizing each resident's cility must protect and of the resident. Facility must provide equal are regardless of diagnosis, in, or payment source. A facility maintain identical policies and transfer, discharge, and the sunder the State plan for all is of payment source. The of Rights. The of Rights is a citizen in the services in the sor her of the facility and as a citizen	F 5				
	free of interference reprisal from the fac- rights and to be sup exercise of his or his subpart.	resident has the right to be coercion, discrimination, and cility in exercising his or her oported by the facility in the er rights as required under this					

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		495226	B. WING _			6/07/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
WΔΥΙ ΔΝΓ	NURSING AND REH	IABILITATION CENTER		730 LUNENBURG HIGHW			
			KEYSVILLE, VA 23947				
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 550	Continued From p	age 8	F 5	50			
	was determined the and promote dignisurvey sample, Resident #10 was 2/21/19 with the dhigh blood pressurpulmonary disease.	admitted to the facility on lagnoses of but not limited to re, chronic obstructive e (2), obstructive and reflux		Resident #10 s catheter bae emptied of urine and proper ensure privacy and dignity. An inspection of other reside indwelling catheters was conthere were no other issues if Nursing staff will be responsimal maintain privacy bags on reindwelling catheters. The Runurse will report any non-concatheter bags to the Cardinal members at their morning a meeting. Non-compliance was corrected immediately. Results of the Cardinal IDT Catheter log will be reviewed.	ents with nducted and found. sible for sidents with N Charge impliance with al IDT nd/or evening vill be meetings		
	lower urinary tract urine. The most reset), a Significant assessment, with date) of 3/18/19, certain 9 out of 15 on the Mental Status) sometime of the moderate cognitive making. The resident welling urinary On 6/4/19 at 3:12 Resident #10's indicated the collection bag was exposed, and han each observation, On 6/5/19 at 8:19 urinary catheter councovered, exposed.	p.m., 4:20 p.m., and 5:18 p.m., lwelling urinary catheter sobserved uncovered, ging on the bed frame. During urine was observed in the bag. a.m., Resident #10's indwelling bllection bag was observed ed, and hanging on the bed sobservation, urine was		Catheter log will be reviewe ensure compliance. The log reviewed by the QAPI commonthly meeting.	s will be		

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	ROVIDER OR SUPPLIER NURSING AND REHAE			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	1 00/07/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
F 550	Continued From pag	e 9	F 55	50		
	conducted with LPN #3. LPN #3 was ask follow in regards to a bag. LPN #3 stated, privacy." LPN #3 was for a Foley collection #3 stated, "Yes. It is nurse takes care of his they have covers. It Tuesday." When asl Foley collection bag have to talk with som On 6/7/19 at 11:48a. Staff Member) #1, th aware of the findings (1) An indwelling catturine from the bladde body. This information website: https://medlineplus.g00140.htm (2) Chronic obstruction Disease that makes lead to shortness of obtained from the we https://www.nlm.nih.g(3) Obstructive and ruropathy is a condition is blocked. This causinjure one or both kicobtained from the we obtained from the weather the state of	neter is a tube that drains er to a bag outside of the on was obtained from the ov/ency/patientinstructions/0 we pulmonary disease: it difficult to breath that can breath. This information was ebsite: gov/medlineplus/copd.html. eflux uropathy: Obstructive on in which the flow of urine less the urine to back up and lineys. This information was				

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		495226	B. WING		C 06/07/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/01/2010
MANI AND	NUDCING AND DELIA	DILITATION CENTED		730 LUNENBURG HIGHW	
WAYLAND NURSING AND REHABILITATION CENTER				KEYSVILLE, VA 23947	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
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F 559	Continued From pa	ge 10	F 55	9	
F 559	Choose/Be Notified	of Room/Roommate Change	F 55	9	7/21/19
SS=D	CFR(s): 483.10(e)(4				
	§483.10(e)(4) The r	ight to share a room with his			
	-	n married residents live in the			
	same facility and bo arrangement.	oth spouses consent to the			
		ight to share a room with his			
		choice when practicable,			
		s live in the same facility and sent to the arrangement.			
	both residents cons	ent to the arrangement.			
		ight to receive written notice,			
	_	n for the change, before the			
	changed.	oommate in the facility is			
	This REQUIREMEN by:	NT is not met as evidenced			
	_	rview, facility document		F-559	
	-	record review, it was		Resident #33 and her resident	
		lity staff failed to provide		representative were provided written	
		nt and/or responsible		explanation as to the reason for mov	ring to
		room change for one of 33		another room within the facility.	
	residents in the sur	vey sample, Resident #33.		No other resident in the facility was identified as not being notified.	
	The facility staff faile	ed to provide the resident and		Approvals for a room move will be	
	_	ntative with a written		discussed in the morning Cardinal IE)T
	notification/explana	tion of why a move was		meeting before a room move is done	e.
		nt #33, prior to a room change		The administrator or his designee wi	II
		to the long-term care unit,		ensure that the Social Worker prope	•
		e an opportunity for the		notifies residents and their RR as to	
	resident to view the	room prior to the move.		reason for a room move and that the resident has viewed the room and m	
	The findings include			any new roommate. Copies of the w notification will be kept in the Social	
		admitted to the facility on		services Office.	
		es that included but were not		Room moves will be completed and	
	limited to: dementia	, high blood pressure,		reported back to the Cardinal IDT	

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	495226 B. WING			C				
NAME OF P	ROVIDER OR SUPPLIER	433220	J:	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	06/	07/2019	
	to the Little of the Country of the				80 LUNENBURG HIGHW			
WAYLAND NURSING AND REHABILITATION CENTER					EYSVILLE, VA 23947			
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F 559	Continued From page	e 11	F 5	559				
	pulmonary disease - nonreversible lung discombination of emphibronchitis) (1). The most recent MDS assessment, an admiassessment reference				members to verify that proper documentation and notifications were completed. Room moves will be monitored weekly by the cardinal IDT members and submitted to the facility QAPI committee for oversight.			
	interview for mental s is severely impaired t decisions. The reside extensive assistance	tatus) score, indication she o make daily cognitive nt was coded as requiring to being dependent upon all of her activities of daily						
	long-term care hall or clinical record reveals previously on the reh	abilitation hall for respite as transferred to long-term						
	documented, "Res. (r XXX A bed, adjusting no problems noted. F Further review of the evidence any docume resident being shown communication with t An interview was con staff member (ASM): 6/5/19 at 4:36 p.m. W #33 was moved from	ed, 6/1/19 at 8:35 p.m., esident) transferred to room to room, ate in dining room, reasont and cooperative." progress notes failed to entation regarding the the room, written or verbal he resident's representative. ducted with administrative #1, the administrator, on reasont the rehabilitation hallway to llway, ASM #1 stated the						

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	ROVIDER OR SUPPLIER NURSING AND REHA	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		00/07/2019	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 559	Tuesday and Thurs just for respite care for at home. She we care through PACE rooms was not a melt that she could be the days she goes to sit up in the front This way she was a front door and can wished for pick up. An interview was comember (OSM) #4 at 4:07 p.m. When change is made in stated, "I call both to the computer under change in the clinic resident and/or fam regarding the room I just call them and Resident #33 or he prior to transfer and the roommate, OSI OSM #4 reviewed to clinical record and writing a note." When transferred rooms, An interview was confo/5/19 at 4:16 p.m. when resident have stated, "The request a notify the roommate to the roommate to the computer of the rooms,"	or the Elderly) program every sday. She was originally here to but could no longer be cared as transferred to long-term. The reason she was moved latter of convenience, it was be closer to the front door for out to PACE. She would have to lobby for an extended period. The moved and is closer to the be sitting in her room if she	F 55	59	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		405220	B. WING	P. WING		С	
		495226	B. WING			06/	07/2019
NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WAYLAND	NURSING AND REHAB	ILITATION CENTER			30 LUNENBURG HIGHW		
				K	(EYSVILLE, VA 23947		
(X4) ID PREFIX	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOU		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
TAG	REGULATORT OR I	130 IDENTIFTING INFORMATION)	TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		
F 559	Continued From page	a 13	_	559			
1 000				ეემ			
	resident representativ	ive the resident and/or					
		nange, ASM #1 stated, "If it's					
		t, I don't believe it is done."					
	•	sident is shown the new					
		, "Yes, of course." When					
	•	Il documented, ASM #1					
	stated, "In the social v						
	The facility policy, "Ro	oom Assignments/Room					
		ed in part, "Rooms are					
	_	in accordance with their					
		eeds, and their payment					
		and the resident's legal					
	•	nterested family member is					
		esident's room or roommate					
	-	otice should be given to the					
		ly when a resident changes					
	rooms or when a resi						
		nd after any room change,					
		I prepare the resident for the					
	_	tor the adjustment to the					
	new room and roomn	nate."					
		trator and ASM #4, the					
	-	int, were made aware of the					
	above findings on 6/6	7/19 at 7:45 a.m.					
	No further information	n was obtained prior to exit.					
	(1) Barron's Dictiona	ry of Medical Terms for the					
		5th edition, Rothenberg and					
	Chapman, page 124.	•					
F 622			F	622			7/21/19
SS=E				_			
55 -	() (-)(-)(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
	§483.15(c) Transfer a	and discharge-					
	§483.15(c)(1) Facility						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED	
		495226	B. WING			C 6/07/2019	
	ROVIDER OR SUPPLIER D NURSING AND REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		0/01/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 622	remain in the facility, discharge the reside (A) The transfer or d resident's welfare and cannot be met in the (B) The transfer or d because the resident sufficiently so the resident sufficiently so the resident sufficiently so the resident of the services provided by (C) The safety of individual endangered due to the status of the resident (D) The health of individual otherwise be endang (E) The resident has appropriate notice, to under Medicare or Monpayment applies submit the necessary payment or after the Medicare or Medicair resident refuses to president who become admission to a facility resident only allowation (F) The facility cease (ii) The facility may be resident while the aps 431.230 of this charge notice from 431.220(a)(3) of this discharge or transfer or safety of the resident into the facility. The facility in the facility. The facility in the safety of the resident into the resident	ermit each resident to and not transfer or at from the facility unless- scharge is necessary for the d the resident's needs facility; scharge is appropriate t's health has improved sident no longer needs the the facility; ividuals in the facility is ne clinical or behavioral t; ividuals in the facility would tered; failed, after reasonable and o pay for (or to have paid tedicaid) a stay at the facility. If the resident does not or paperwork for third party third party, including d, denies the claim and the ay for his or her stay. For a tes eligible for Medicaid after or the facility may charge a the charges under Medicaid;	F 6.	22			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495226	B. WING		C 06/07/2019		
	ROVIDER OR SUPPLIER O NURSING AND REHA	BILITATION CENTER	7	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 622	resident under any of in paragraphs (c)(1) section, the facility ror discharge is documedical record and communicated to the institution or provided (i) Documentation in must include: (A) The basis for the (i) of this section. (B) In the case of passection, the specific be met, facility attenneeds, and the service facility to meet the needs, and the service facility attention (a) The documentation (b) of this section. (iii) Information provenust include a minimum (b) Contact information provenust include a minimum (c) Advance Direction (d) All special instruction (d) Comprehensive	mentation. Insfers or discharges a of the circumstances specified (i)(A) through (F) of this must ensure that the transfer imented in the resident's appropriate information is e receiving health care er. In the resident's medical record the transfer per paragraph (c)(1) aragraph (c)(1)(i)(A) of this resident need(s) that cannot inputs to meet the resident ice available at the receiving eed(s). In on required by paragraph (c) must be made byhysician when transfer or ary under paragraph (c) (1) aragraph (c)(1)(i)(C) or (D) of ided to the receiving provider mum of the following: tion of the practitioner care of the resident. In the circumstance is regarded to the receiving provider mum of the following: tion of the practitioner care of the resident. In the circumstance is regarded to the receiving provider mum of the following: tion of the practitioner care of the resident. In the circumstance is receiving provider mum of the following: tion of the practitioner care of the resident. In the circumstance is the circumstance is the circumstance is the circumstance is the circumstance in the circumstance is the	F 622				

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B. WING _				C 06/07/2019	
	ROVIDER OR SUPPLIER NURSING AND REHA	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	DDE I	00/	0772013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIAT		(X5) COMPLETION DATE	
F 622	consistent with §48 any other documen a safe and effective This REQUIREMEN by: Based on staff intereview, and clinical failed to evidence the documentation was required transfer documentation facility for transfers for nine of Residents #41, #22 #46, and #19. The findings included 1. The facility staff physician documentation was facility when Residence what, if and documentation was facility when Resident #41 was a 7/10/18 with the dia acute respiratory fapressure, anxiety didisorder, atrial fibrill chronic obstructive osteoporosis. The Data Set) was a significant with an ARD (Asses 5/3/19. The resident moderately impaired decisions.	It's discharge summary, 3.21(c)(2) as applicable, and tation, as applicable, to ensure a transition of care. NT is not met as evidenced rview, facility document record review, the facility staff that the required physician completed and/or the recumentation was provided to perfacility initiated hospital and sampled residents, 1, #25, #13, #15, #43, #49, as: failed to evidence the required tation was completed and the required transfer approvided to the receiving ent #41 was transferred to the	F 6	F-622 Physician documentation for obtained for resident #s 41, 15, 43, 49, 46 and 19. A coresident was sent to the recident was sent to the recident was conducted and no other found. The medical director will be the necessary documentation transfers. Nursing staff will on the necessity to include comprehensive care plan grunplanned discharges will the Cardinal IDT members a meeting to ensure that all did and transfer papers are sen of unplanned discharges with the team and reviewed week compliance. Results of the Unplanned Did will be submitted to the QAF at its monthly meeting for ordirection.	22, 25, 13, ppy of the ch affected beiving the last 30 dater issues were in-serviced from required from the resident to als. The reviewed at its morning ocumentation that an audit to lill be kept by ekly for the py committee of the committee of	ays re on for ed □s by g n pool		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED		
		495226	B. WING			C 06/07/2019	
	ROVIDER OR SUPPLIER NURSING AND REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		00/07/2019	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	-	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 622	following nurses note "Therapy alerted writ (complaining of) state [oxygen] sats [satura @ (at) 3L/M (three lift assess resident. Repain in left arm, non-(shortness of breath) O2@3L/M. Residen questions. Speech spressure) 130/64, HI (respiratory rate) 22. Practitioner) made a send to ER (emerger evaluation. Bed hold and sent with resider (responsible represer Further review of the reveal any evidence documentation was pfacility. There was no physician documentation was president to prevent why the facility was resident's needs, and hospital could providing facility could not) was an interview was corpractical nurse) #5 or regarding the paper resident being transfitstated, "The DNR [deimmunization record med (medication) list the ER [emergency resident).	e: 4/16/19 at 3:39 PM: ter that resident was c/o bing pain in left arm and o2 tions] were in the 80's on O2 ters per minute). Writer in to sident continues to c/o sharp radiating. C/o SOB b. O2 sats 90% on t slow to respond to writers slurred at times. B/P (blood R (heart rate) 134, RR (Name of Nurse ware and orders received to ncy room) for further d policy placed in paperwork nt. Resident is her own RR ntative) and aware." c clinical record failed to of what, if any, required provided to the receiving o evidence that the required ation (what efforts the facility the need for hospitalization, not able to meet the d what specific services the e for the resident that the s completed. nducted with LPN (licensed n 6/5/19 at 2:37 p.m., work the facility sends with a terred to the hospital. LPN #5 to not resuscitate] form, bed hold policy, copy of the t, copy of the order to send to room]." When asked where	F	522			
	immunization record med (medication) list the ER [emergency r staff documents wha	, bed hold policy, copy of the t, copy of the order to send to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	COMPLETED	
		495226	B. WING		C 06/07/2019
	ROVIDER OR SUPPLIER D NURSING AND REHA	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	1 00/01/2013
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDE DEFICIENCY)	D BE COMPLETION
F 622	we send all of that. bed hold." When a care plan goals are stated, "No, I don't form that has if they the reason they are insurance informatii information for the When asked if the writes a note as to hospital, LPN #5 st resident comes bac were sent to the ho On 6/06/19 at 7:08 #4, she stated that hospital, the facesh (Medication Admini policy are sent. Sh not use a transfer for are not sent; and the requirements for ph When asked how the required documentate hospital, LPN #4 st note, which we don know what was send the commentation the hospital for residen #2 stated, "Face sh DNR [do not resusc [emergency room], lab (laboratory) or call the hospital with the send that the care in	We do write a note about the sked if the comprehensive sent with residents, LPN #5 usually. We send the transfer are continent or incontinent, going to the ER, their on, vital signs and the contact resident representative." doctor or nurse practitioner why the resident went to the ated, "Sometimes when the sk they will document why they spital." p.m., in an interview with LPN when a resident is sent to the leet, code status, current MAR stration Record) and bed hold the stated that the facility does form; that the care plan goals hat she did not know what the large in the facility evidences that all the ated, "Unless you put it in a "t really, there isn't a way to it."	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		IPLE CONSTRUCTION NG	· /	(X3) DATE SURVEY COMPLETED	
		495226	B. WING			C 06/07/2019	
	ROVIDER OR SUPPLIER NURSING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP COI 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		06/07/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 622	ASM #2 stated, "No, the doctor's write a not to the hospital, ASM and to the hospital, ASM and the hospital, ASM and the hospital to remain transfer or discharge unless: a) The transfor the resident's welf cannot be met in the have documentation record that the above The resident's attend documentation that so "b" have occurred	we do not." When asked if ote of why the resident went #2 stated, "Sometimes." / policy, "Transfer and ted, "The facility will permit ain in the facility, and not the resident from the facility fare and the resident's needs facility; The facility will in the resident's medical esituations have occurred in physician will provide ituations discussed in "a" or before a facility transfers or the facility will: *Notify the in, a family member or legal transfer or discharge and ove in writing and in a rethey understand. *Record esident's clinical record." Jude any criteria for the of the physician ospital transfer; the specific must be provided to the a hospital transfer; written budsman, or the provision policy.	Fé	522			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495226	B. WING		06/07/2019	a
	ROVIDER OR SUPPLIER D NURSING AND REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	1 00/01/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLE	ETION
F 622	and reduce fever. Information obtained		F 6.	22		
	physician documenta evidence that all requ was provided to the i	ailed to evidence the required ation was completed and uired transfer documentation receiving facility when ansferred to the hospital on				
	11/23/12 with the dia dementia, atrial fibrill kidney disease, Alzh psychotic disorder. (Minimum Data Set) with an ARD (Assess 6/3/19. The resident	The most recent MDS was an annual assessment sment Reference Date) of				
	note dated 3/11/19 a Resident #22 was se from the wheelchair i documented in part, notified and gave ord (emergency room) fo RR (resident represe Resident left facility a rescue squad)." A nu	al record revealed a nurse's to 9:15 a.m., that documented ent to the hospital after a fall for evaluation. The note "NP (nurse practitioner) was ler to send to ER or eval (evaluation) and treat. Entative) made aware. at 0900 (9:00 AM) via (county larse's note dated 3/11/19 at d, "Copy of bed hold policy				
		clinical record revealed an Transfer Form" which				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	· ,	(X3) DATE SURVEY COMPLETED	
		495226	B. WING _			C 6/ 07/2019	
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		010112013	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 622	information, code Precautions, Skin. information, Reha for transfer, Key C status, where the representative information. There was no dooresident's treatme provided. The are RespiratoryDiet blank. There was Medication Admin Administration Re provided. There was formation the formation of the formation. Further review of the formation of the	esident's demographic status, Risk Alerts, Isolation //Wound Care, facility contact bilitation Therapy status, reason clinical Information, functional resident was sent to, resident ormation, and mental status. Sumented evidence of the ints and medications being sea titled "Treatments: tMedications" were all left no evidence that a copy of the istration Record and Treatment cord (MAR and TAR) were was no evidence that the are plan goals were provided. In was dated 3/11/19 and the signs were dated 3/11/19; a documented that the date of	F	522			

ITATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		` ′	(X3) DATE SURVEY COMPLETED		
	495226	B. WING			C 06/07/2019
ROVIDER OR SUPPLIER D NURSING AND REHA	ı		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	l	06/07/2019
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE
message for RR (restacility. 0940 (9:40 / 0945 (9:45 AM) Restand 2 attendants. A and no answer. 124 representative) mad Further review of the "SNF/NF to Hospital 4/29/19. The form demographic information Alerts, Isolation Prestacility contact information Rehabilitation Theratical Information Rehabilitation Theratical Information RespiratoryDiet blank. There was not Medication Administration Recoprovided. There was comprehensive care An interview was co (administration the familiar for residents #2 stated, "Face she DNR [do not resusci [emergency room], klab (laboratory) or x-	AM) Rescue squad arrived. ident left facility via stretcher ttempted to call report to ER to (12:40 PM) RR (resident e aware of above." Transfer Form" dated locumented the resident's ation, code status, Risk cautions, Skin/Wound Care, nation. It also documented py status, reason for transfer, tion, functional status, where not to, and resident mation. There was no ce of the resident's ications being provided. The ents: Medications" were all left to evidence that a copy of the ration Record and Treatment and (MAR and TAR) were son o evidence that the eplan goals were provided. Inducted with ASM member) #2,, the director of to 2:47 p.m., regarding what acility provide to the receiving so that are transferred. ASM the ped hold policy, immunization, tray results. I then call 911,	F 62	22		
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN' REGULATORY OF Continued From page message for RR (restacility. 0940 (9:40 / 0945 (9:45 AM) Restand 2 attendants. A and no answer. 124 representative) mad Further review of the "SNF/NF to Hospital 4/29/19. The form of demographic informal Alerts, Isolation Preceditive Contact informal Rehabilitation Theral Key Clinical Informathe resident was ser representative informathe resident was ser representative informathe resident was ser representative Diet blank. There was not make a titled, "Treatmer Respiratory diet make a titled, "Treatmer Respiratory diet make a titled, "Treatmer Respiratory diet make a titled, "Treatmer Respir	A95226 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 message for RR (resident representative) to call facility. 0940 (9:40 AM) Rescue squad arrived. 0945 (9:45 AM) Resident left facility via stretcher and 2 attendants. Attempted to call report to ER and no answer. 1240 (12:40 PM) RR (resident representative) made aware of above." Further review of the clinical record revealed an "SNF/NF to Hospital Transfer Form" dated 4/29/19. The form documented the resident's demographic information, code status, Risk Alerts, Isolation Precautions, Skin/Wound Care, facility contact information. It also documented Rehabilitation Therapy status, reason for transfer, Key Clinical Information, functional status, where the resident was sent to, and resident representative information. There was no documented evidence of the resident's treatments and medications being provided. The area titled, "Treatments: RespiratoryDietMedications" were all left blank. There was no evidence that a copy of the Medication Administration Record and Treatment Administration Record (MAR and TAR) were provided. There was no evidence that the comprehensive care plan goals were provided. An interview was conducted with ASM (administrative staff member) #2,, the director of nursing, on 6/5/19 at 2:47 p.m., regarding what documentation the facility provide to the receiving hospital for residents that are transferred. ASM #2 stated, "Face sheet, med [medication] list, DNR [do not resuscitate], order to send to the ER [emergency room], bed hold policy, immunization, lab (laboratory) or x-ray results. I then call 911, call the hospital with report." When asked if the staff send the comprehensive care plan goals,	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 message for RR (resident representative) to call facility. 0940 (9:40 AM) Rescue squad arrived. 0945 (9:45 AM) Resident left facility via stretcher and 2 attendants. Attempted to call report to ER and no answer. 1240 (12:40 PM) RR (resident representative) made aware of above." Further review of the clinical record revealed an "SNF/NF to Hospital Transfer Form" dated 4/29/19. The form documented the resident's demographic information, code status, Risk Alerts, Isolation Precautions, Skin/Wound Care, facility contact information. It also documented Rehabilitation Therapy status, reason for transfer, Key Clinical Information. 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When asked if the	ROVIDER OR SUPPLIER D NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH OPEN MEXT SEEDED BY FULL (RACH OPEN MEXT SEEDED BY FULL (REQUILATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 message for RR (resident representative) to call facility. 0940 (9:40 AM) Rescue squad arrived. 0945 (9:45 AM) Resident left facility via stretcher and 2 attendants. Attempted to call report to ER and no answer. 1240 (12:40 PM) RR (resident representative) made aware of above." Further review of the clinical record revealed an "SINFIN' to Hospital Transfer Form" dated 4/29/19. The form documented the resident's demographic information, code status, Risk Allerts, Isolation Precautions, Skin/Wound Care, facility contact information, incitional status, where the resident was sen to, and resident representative information. There was no edicence that a copy of the Medication Administration Record (MAR and TAR) were provided. 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Attempted to call report to ER and no answer. 1240 (1240 PM) RR (resident representative) to representative) made aware of above." Firther review of the clinical record revealed an "SNF/NF to Hospital Transfer Form" dated 4/29/19. The form documented the resident's demographic information, code status, Risk Alerts, Isolation Precautions, Skin/Wound Care, facility contact information. It also documented Rehabilitation Threapy status, reason for transfer, Key Clinical Information, functional status, where the resident was sent to, and resident's treatments and medications being provided. The area titled, "Treatmentis: RespiratoryDietMedications" were all left blank. There was no evidence that a copy of the Medication Administration Record and Treatment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495226	B. WING				C (07/2019	
	ROVIDER OR SUPPLIER D NURSING AND REHAE	BILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		SURG HIGHW	06/07/2019		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	- '	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 622	the doctor's write a n to the hospital, ASM On 6/6/19 at 7:43 PN Administrator), ASM Nurse Consultant) w ASM #1 inquired aborequired transfer info stated that the facility form. 3. The facility staff for required documental receiving facility whe transferred to the hospital Resident #25 was ac 7/30/18, with the diagongestive heart failed.	ailed to evidence what, if any ion was provided to the n Resident #25 was spital on 3/24/19. In Ash with the #2 and Ash #4 (Facility ere notified of the concerns. But a transfer form for the formation and Ash #2 then are does not use a transfer which will be a transfer when the n Resident #25 was spital on 3/24/19. In the facility on gnoses of but not limited to, oure, dementia, depression,	F	522				
	(Minimum Data Set) with an ARD (Assess 5/26/19. The resider impaired in ability to A review of the clinic note on 5/26/19 that was sent to the hosp The note documente "Order to send to ER evaluation. RP agre res, transferred to (n town). Res. picked u (county) rescue square	to reveal any evidence of						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495226	B. WING			C 06/07/2019	
	ROVIDER OR SUPPLIER D NURSING AND REHA	ABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CO 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			50/07/2019	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 622	evidence of a trans much of the require An interview was co (administrative staff nursing, on 6/5/19 a documentation the hospital for resident #2 stated, "Face sh DNR [do not resusc [emergency room], lab (laboratory) or x call the hospital with staff send the comp ASM #2 stated, "Not the doctor's write a	eiving facility. There was no fer form which would contain and information was completed.	F 62	2			
	Nurse Consultant) of ASM #1 inquired above required transfer in stated that the facility form. (1) BNP - Brain national blood test that mea BPN that is made bovessels. BNP levels you have heart fails Information obtaine https://medlineplus.	M #2 and ASM #4 (Facility were notified of the concerns. bout a transfer form for the formation and ASM #2 then ity does not use a transfer triuretic peptide (BNP) test is a sures levels of a protein called by your heart and blood is are higher than normal when ure.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495226	B. WING				07/2040
NAME OF PE	ROVIDER OR SUPPLIER	400220		S	TREET ADDRESS, CITY, STATE, ZIP CODE	06/	07/2019
	NURSING AND REHAB	ILITATION CENTER		7	30 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	Information obtained https://medlineplus.gottml (3) Levaquin - is an all Information obtained https://medlineplus.gottml	from ov/druginfo/meds/a682858.h ntibiotic.	F	622			
	documentation was p facility when Resident hospital on 2/15/19. Resident #13 was addiagnoses of atrial fib depression, chronic of disease, anxiety disordisease, anxiety disord	rder, intestinal obstruction, ry failure, and neurogenic cent MDS (Minimum Data change assessment with an eference Date) of 3/22/19. ed as moderately impaired y life decisions. Il record revealed a nurse 9:00 a.m., that documented to the hospital for ing. The note documented "FNP (Family Nurse and order received to send om) for eval (evaluation) and age for RR. Bed Hold policy o ER."					
	Further review of the "SNF/NF to Hospital"						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)	PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV DENTIFICATION NUMBER: A. BUILDING (X3) DATE SURV COMPLETE					
	495226	B. WING _				C / 07/2019
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILIT	TATION CENTER		STREET ADDR 730 LUNENB KEYSVILLE		, 00.	
PREFIX (EACH DEFICIENCY MI	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
status, reason for transfer Information, functional status was sent to, and resident information. The area titted RespiratoryDietMeet that the resident was on chronic condition, and we however, the reason was was the dose. In addition or treatments were docuted evidence that a copy of a Administration Record a Administration Record (Improvided. There was not comprehensive care plant the receiving hospital. An interview was conduct (administrative staff mention nursing, on 6/5/19 at 2:4 documentation the facility hospital for residents that #2 stated, "Face sheet, in DNR [do not resuscitated [emergency room], bed I lab (laboratory) or x-ray call the hospital with reputation the comprehents and the comprehents and the comprehents was sent to the comprehents of the comprehents was sent to the comp	ted the resident's in, code status, Risk ions, Skin/Wound Care, on, Rehabilitation Therapy er, Key Clinical tatus, where the resident at representative ided "Treatments: dications" documented nebulizer therapy for a as on Macrobid (3). Is not documented nor in, no other medications imented. There was no the Medication and Treatment in MAR and TAR) were evidence that the in goals were provided to incident in goals were provided to incident in goals were provided to incident in goals were incident in goals. If then call goals, do not." When asked if the insive care plan goals, do not. When asked if of why the resident went in goals in goals. The goals in goals in goals, were plan goals, do not. The goals in goals in goals, do not. The goals in goals in goals in goals. The goals in goals in goals in goals in goals in goals in goals. The goals in goals. The goals in goals. The goals in goals i	F	522			

NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER BY LEACH DEPCINE (EACH DEPCINE ON YUST SE PRECEDED BY FULL REGULATORY OR I.S. IDENTIFYING INFORMATION) F 622 Continued From page 27 ASM #1 inquired about a transfer form for the required transfer information and ASM #2 then stated that the facility does not use a transfer form. (1) Zofran - is used to prevent nausea and vomiting, information obtained from https://medlineplus.gov/druginfo/meds/a601209.html (2) Phenergan - is used to prevent and control nausea and vomiting. Information obtained from https://medlineplus.gov/druginfo/meds/a682284.html 5. The facility staff failed to evidence that all required physician documentation was completed and evidence what, if any, required transfer documentations was provided to the receiving facility when Resident #15 was transferred to the hospital on 4/11/19. Resident #15 was admitted to the facility on 12/2/13 with the diagnoses of but not limited to dementia, with behavioral disturbances, anxiety disorder, Huntington's disease (1) and history of falling. The most received M3/6 (Minimum Data Set), a Quarterly Medicare assessment, with an SEO, a Quarterly Medicare assessment.		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION		OATE SURVEY COMPLETED
STREETADDRESS_CITY, STATE, ZIP CODE			495226	B. WING			
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 622 Continued From page 27 ASM #1 inquired about a transfer form for the required transfer information and ASM #2 then stated that the facility does not use a transfer form. (1) Zofran - is used to prevent nausea and vomiting. Information obtained from https://medlineplus.gov/druginfo/meds/a601209.h tml (2) Phenergan - is used to prevent and control nausea and vomiting. Information obtained from https://medlineplus.gov/druginfo/meds/a682284.h tml 5. The facility staff failed to evidence that all required physician documentation was completed and evidence what, if any, required transfer documentations was provided to the receiving facility when Resident #15 was transferred to the hospital on 4/11/19. Resident #15 was admitted to the facility on 1/2/2/13 with the diagnoses of but not limited to dementia, with behavioral disturbances, anxiety disorder. Huntington's disease (1) and history of falling. The most recent MDS (Minimum Data Set), a Quarterly Medicare assessment, with an			1		730 LUNENBURG HIGHW	I	00/01/2019
ASM #1 inquired about a transfer form for the required transfer information and ASM #2 then stated that the facility does not use a transfer form. (1) Zofran - is used to prevent nausea and vomiting. Information obtained from https://medlineplus.gov/druginfo/meds/a601209.h tml (2) Phenergan - is used to prevent and control nausea and vomiting. Information obtained from https://medlineplus.gov/druginfo/meds/a682284.h tml 5. The facility staff failed to evidence that all required physician documentation was completed and evidence what, if any, required transfer documentations was provided to the receiving facility when Resident #15 was transferred to the hospital on 4/11/19. Resident #15 was admitted to the facility on 12/2/13 with the diagnoses of but not limited to dementia, with behavioral disturbances, anxiety disorder, Huntington's disease (1) and history of falling. The most recent MDS (Minimum Data Set), a Quarterly Medicare assessment, with an	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API	IOULD BE	COMPLETION
ARD (Assessment reference date) of 4/3/19, coded the resident per staff assessment, as having short-term memory problems, long-term memory problems, and severe impairment of daily decision-making. A review of the clinical record revealed a nurse's noted dated 4/11/19 at 02:21 a.m., that	F 622	ASM #1 inquired aborequired transfer infostated that the facility form. (1) Zofran - is used to vomiting. Information obtained https://medlineplus.gtml (2) Phenergan - is used to vomiting. Information obtained https://medlineplus.gtml 5. The facility staff farequired physician down devidence what, is documentations was facility when Resider hospital on 4/11/19. Resident #15 was accompacted to the property of the coded the resident phaving short-term memory problems, adaily decision-making.	out a transfer form for the simulation and ASM #2 then is does not use a transfer or prevent nausea and from ov/druginfo/meds/a601209.h sed to prevent and control is from ov/druginfo/meds/a682284.h siled to evidence that all ocumentation was completed from any required transfer provided to the receiving out #15 was transferred to the disturbances, anxiety is disease (1) and history of the the MDS (Minimum Data dicare assessment, with an efference date) of 4/3/19, the staff assessment, as the emory problems, long-terminal severe impairment of green and record revealed a nurse's and control of the emory problems and record revealed a nurse's and record revea	F 62	22		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495226	B. WING			C 06/07/2019
	ROVIDER OR SUPPLIER D NURSING AND REHAL	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	•	0/0//2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 622	Continued From pag	e 28	F 6	22		
		rent injury foundWill send oom] for evaluation and				
	physician's note doc	al record failed to reveal a umenting the reason for fer to the hospital on 4/11/19.				
	nursing, on 6/5/19 ard documentation the fathospital for residents #2 stated, "Face she DNR [do not resusci [emergency room], but lab (laboratory) or x-call the hospital with staff send the compropersion ASM #2 stated, "No, the doctor's write a redocumentation to the fathospital states are stated, and the staff send the compropersion to the staff send the compropersion to the staff send the staff send the compropersion to the staff send	inducted with ASM member) #2,, the director of it 2:47 p.m., regarding what acility provide to the receiving is that are transferred. ASM itet, med [medication] list, itate], order to send to the ER ited hold policy, immunization, iray results. I then call 911, ireport." When asked if the itehensive care plan goals, ive do not." When asked if itete of why the resident went item 12 stated, "Sometimes."				
	Staff Member) #1, th	.m., ASM (Administrative e Administrator, was made s. No further information was of the survey.				
	that causes certain r waste away. People gene, but symptoms middle age. Early sy uncontrolled movem balance problems. L ability to walk, talk, a stop recognizing fam	pase: is an inherited disease therve cells in the brain to are born with the defective usually don't appear until mptoms of HD may include ents, clumsiness, and ater, HD can take away the and swallow. Some people hilly members. Others are nment and are able to				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG	(X:	3) DATE SURVEY COMPLETED
		495226	B. WING _			C 06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	DDE	33/01/2313
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 622	Continued From page express emotions. The from the following we https://vsearch.nlm.nmeta?v%3Aproject=redlineplus-bundle& ase&_ga=2.1144981 904618792.1557758 6. The facility staff farequired transfer door the receiving facility with transferred to the hose 5/6/19, and all required transferred to the hose completed when transferred to the hose completed when transferred to the hose completed with the diagonal dementia with behave all the complete co	this information was obtained ebsite: ih.gov/vivisimo/cgi-bin/query-medlineplus&v%3Asources= aquery=huntington%27s+dise 81.349992197.1560176578- 561 illed to evidence what, if any, aumentations was provided to when Resident #43 was spital on 4/12/19, 5/5/19 and ed physician documentation in Resident #43 was spital on 5/5/19. Imitted to the facility on noses of but not limited to	F 6	DEFICIENCY		
	assessment as having problems, long-term moderate impairment. A review of the clinical noted dated 4/12/19 in part, "Upon entering on floor in front of be Practitioner) notified to ER (Emergency R	•				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495226	B. WING		C 06/07/2019
	ROVIDER OR SUPPLIER D NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	, 33.0.122.13
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 622	documented in part (name of) hospital 4 have a urinary tract A review of the clini that the required traprovided to the rece #43's transfer to the A review of the clini noted dated 5/5/19 in part, "Called to rocalled FNP and or (emergency room) treatment" A review of the clini physician's note documents includin plan, were provided Resident #43's tran Further review failed documents includin plan, were provided Resident #43 was to 5/5/19. A review of the clini noted dated 5/6/19 in part, "Resident wheezecalled (na ER for evaluation A review of the clini physician's note dated documented in part (name of) hospital sound to have an El found to h	red 4/13/19 at 10:45 a.m., , "She was evaluated at k/12/19She was found to	F 62.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION G	COM	PLETED
		495226	B. WING		1	
	ROVIDER OR SUPPLIER NURSING AND REH	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	DRRECTION (X5) N SHOULD BE COMPLE E APPROPRIATE DATE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 622	the required docume comprehensive cal receiving facility with transferred to the hand interview was considered and interview was con	cical record failed to evidence ments including the re plan, were provided to the men Resident #43 was mospital on 5/6/19. Conducted with ASM ff member) #2., the director of at 2:47 p.m., regarding what facility provide to the receiving mosts that are transferred. ASM meet, med [medication] list, citate], order to send to the ER bed hold policy, immunization, ex-ray results. I then call 911, the report." When asked if the prehensive care plan goals, o, we do not. When asked if a note of why the resident went M #2 stated, "Sometimes." AM, ASM (Administrative Staff dministrator, was made aware of further information was dof the survey.	F 62	,		
	required transfer d the receiving facilit transferred to the h Resident #49 was 4/23/19 with the di type 2 diabetes me heart failure, chron disease (1), obstru	failed to evidence what, if any, ocumentation was provided to y when Resident #49 was nospital on 5/12/19. admitted to the facility on agnoses of but not limited to ellitus, high blood pressure, iic obstructive pulmonary ctive and reflux uropathy (2), ine. The most recent MDS				

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	(X3)) DATE SURVEY COMPLETED
		495226	B. WING _			C 06/07/2019
	OVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	ODE	00/01/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO TIVE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 622	date) of 5/28/19, cod 6 out of 15 on the Bli Mental Status) score severe cognitive imp making. A review of the clinic note dated 5/12/19 a part, "No acute chan Practitioner) aware of chest pain and gave (Emergency room) A review of the clinic physician's note dated documented in part, (name of) Hospital 5 exacerbation of his of the clinic and if any of the requiremental provided to the receing a was transferred. An interview was correctly was transferred.	a 14-day Medicare ARD (Assessment reference ed the resident as scoring a MS (Brief Interview for r, indicating the Resident had airment for daily decision al record revealed a nurse's t 9:16 PM, documented in ges. (Name of) NP (Nurse of resident's complaints of order to transport to ER ." al record revealed a ed 5/15/19 at 10 PM, "He was evaluated at //13/19 - 5/15/19 for congestive heart failure" al record failed to reveal what uired information was ving facility when Resident to the hospital on 5/12/19.	F6	522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B. WING				07/0040
NAME OF PI	ROVIDER OR SUPPLIER	433220	B. Wille		STREET ADDRESS, CITY, STATE, ZIP CODE	1 06/	07/2019
WAYLAND	NURSING AND REHAB	ILITATION CENTER			30 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	to the hospital, ASM and the findings. No further f	ote of why the resident went #2 stated, "Sometimes." M, ASM (Administrative Staff ninistrator, was made aware rither information was of the survey. The pulmonary disease: the difficult to breath that can breath. This information was besite: pov/medlineplus/copd.html. The flux uropathy: Obstructive on in which the flow of urine less the urine to back up and neys. This information was	F	622			
	transfer documentation receiving facility when transferred to the hose Resident #46 was ad 9/18/17 with the diagningh blood pressure, chronic obstructive purasthma. The most resulting the Set), a five-day Medical ARD (Assessment recoded the resident as the BIMS (Brief Interview).						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495226	B. WING _			C 06/07/2019
	ROVIDER OR SUPPLIER D NURSING AND REHAI	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		00/01/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 622	impairment for daily resident required ext total care for hygiend and transfers; and w bladder and bowel. A review of the clinic note dated 5/28/19 a part, " order receiv Practitioner) to send eval and treatment A review of the clinic physician's note dated documented in part, (name of) Hospital 5 pain" A review of the clinic required transfer doc transfer to the hospit to the receiving facili An interview was cor (administrative staff nursing, on 6/5/19 at documentation the fahospital for residents #2 stated, "Face she DNR [do not resusci [emergency room], blab (laboratory) or x-call the hospital with staff send the compra ASM #2 stated, "No, the doctor's write a reto the hospital, ASM	decision making. The densive assistance for eating: a, bathing, dressing, toileting, as always incontinent of all record revealed a nurse's at 8:44 AM, documented in ed from FNP (Family Nurse to ER (Emergency room) for ." all record revealed a ed 5/20/19 at 8:45 PM, She was hospitalized at ./28/19 - 6/3/19 for abdominal all record failed to reveal cuments of Resident #46's eal on 5/28/19 was provided ty.	F6	522		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		495226	B. WING			1	C /07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAE	BILITATION CENTER		730	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW /SVILLE, VA 23947	1 00	0112013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 622	Continued From page	e 35	F	522			
	of the findings. No further provided by the end of	•					
	Disease that makes in lead to shortness of the obtained from the we https://www.nlm.nih.go. The facility staff far facility the comprehe	te pulmonary disease: t difficult to breath that can breath. This information was bisite: gov/medlineplus/copd.html. iled to provide the receiving nsive care plan goals upon fer to the hospital on 3/7/19.					
	1/5/17 with a recent r diagnoses that includ diabetes, high blood falls and anemia (co	Imitted to the facility on readmission on 3/11/19 with led but were not limited to: pressure, stroke, history of ndition in which the of the blood is below normal					
	assessment, a quarte assessment reference resident as scoring a interview for mental s	S (minimum data set) erly assessment, with an e date of 5/28/19, coded the "4" on the BIMS (brief status) score, indicating the y impaired to make daily					
	documented in part, observed resident on beside his bed. He to to stand from wheeld completedNeurologhe did not hit his hea pain in right abdomer of 1-10 and complain	ed, 3/7/19 at 10:45 a.m. "Hearing resident call out, I floor laying on his right side ells nurse that he was trying hair. Nursing assessment gical assessment, tells nurse d. Resident complains of n rating 9 on the pain scale is of shoulder pain. NP hade aware with orders to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3)	(X3) DATE SURVEY COMPLETED	
		495226	B. WING			C 06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		00/01/2019
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 622	send to ER (emerger RR (resident repres	cy room) for evaluation. sentative) made aware,	F 62	22		
		(name of hospital)." dated 3/7/19 documented, (evaluation), S/P (status				
	staff member (ASM): on 6/5/19 at 2:47 p.m paperwork is sent wit the hospital, ASM #2 med list, DNR form, of hold policy, immuniza- laboratory or x-ray re facility sends a copy	h a resident on transfer to stated, "The face sheet, order to send to the ER, bed				
	and ASM #4, the faci	nember (ASM) #1, ASM #2 ity-nursing consultant, were pove findings on 6/6/19 at				
		n was provided prior to exit.				
F 623 SS=E	Non-Medical Reader, Chapman, page 33. Notice Requirements	y of Medical Terms for the 5th edition, Rothenberg and Before Transfer/Discharge -(6)(8)	F 62	23		7/21/19
	§483.15(c)(3) Notice Before a facility trans resident, the facility n (i) Notify the resident	fers or discharges a nust-				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	` '	COMPLETED		
		495226	B. WING _			C 06/07/2019		
	ROVIDER OR SUPPLIER D NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		00/01/2013		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 623	representative(s) of the reasons for the language and mann facility must send a representative of the Long-Term Care On (ii) Record the reasons for the language and mann facility must send a representative of the Long-Term Care On (ii) Record the reasons discharge in the result and (iii) Include in the notation paragraph (c)(5) of \$483.15(c)(4) Timin (i) Except as specific (c)(8) of this section discharge required made by the facility resident is transferred (ii) Notice must be represented to the endangered und this section; (B) The health of incomposition be endangered, under this section; (C) The resident's hallow a more immediate the required by the resident days. §483.15(c)(5) Contests	the transfer or discharge and move in writing and in a er they understand. The copy of the notice to a e Office of the State houdsman. Ons for the transfer or ident's medical record in ragraph (c)(2) of this section; of the notice the items described in this section. If of the notice the items described in this section. If of the notice the items described in this section this section that it is section to the notice of transfer or under this section must be at least 30 days before the end or discharged. In and a soon as practicable	F 6	23				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		495226	B. WING _			C 06/07/2019	
	ROVIDER OR SUPPLIER NURSING AND REHAE			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		0/07/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDEDICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 623	(iii) The location to w transferred or discha (iv) A statement of the including the name, a and telephone numbreceives such request to obtain an appeal of completing the form a hearing request; (v) The name, addrest telephone number of Long-Term Care Om (vi) For nursing facility and developmental disabilities, the mailing telephone number of the protection and acceptode developmental disabilities, the mailing telephone number of the protection and acceptode developmental disabilities of the Developmental disabi	owing: Insfer or discharge; Insfer or discharge; Inch the resident is Insert or discharge; Insert or discharge; Insert or discharge; Insert or discharge in Insert or discharge; Insert or discharge in Insert or discharge; Insert or discha	F 6	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495226	B. WING _			C 06/07/2019		
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE	1 00/	0112013	
				730 LUNE	ENBURG HIGHW			
WAYLAND	NURSING AND REHAB	ILITATION CENTER			LLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 623	Continued From page	e 39	F 6	23				
	In the case of facility the administrator of the written notification pri to the State Survey A State Long-Term Can the facility, and the rewell as the plan for the relocation of the residual as the plan for the relocation of the residual as the plan for the relocation of the residual as the plan for the relocation of the residual as the plan for the relocation of the residual are determined that the fathat the Ombudsman representative was proposed as the fathat the Ombudsman representative was provided to the surve #22, #25, #13, #15, # The findings include: 1. The facility staff fathat written notification of provided to the residual Resident #41 was trade 4/16/19. Resident #41 was ad 7/10/18 with the diagracute respiratory failual pressure, anxiety discidisorder, atrial fibrillate chronic obstructive pressure.	acility staff failed to evidence and/or resident rovided the required written tal transfer for nine of 33 y sample; Residents #41, 43, #49, #46, and #19. illed to evidence the required a hospital transfer was ent representative when insferred to the hospital on moses of but not limited to, are, diabetes, high blood order, breast cancer, bladder ion, congestive heart failure, ulmonary disease, and		Omb notifi resid and A re- prev othe Unp the 0 keep notifi repri done daily The wee com will b	resident representative and the budsman were sent proper written fication of a hospital transfer for dent #s 41, 22, 25, 13, 15, 43, 49, 49, 40, 41, 42, 43, 49, 41, 42, 43, 49, 41, 42, 43, 44, 44, 44, 44, 44, 44, 44, 44, 44	he no d by vill as e gs		
	chronic obstructive pu osteoporosis. The m			111011	·····,·			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495226	B. WING			C 06/07/2019	
	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		00/07/2013	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 623	Continued From pag	ge 40	F 6	23			
	5/3/19. The resider moderately impaired decisions.	sment Reference Date) of at was coded as being at in ability to make daily life at record revealed the re: 4/16/19 at 3:39 PM:					
	"Therapy alerted wr (complaining of) sta [oxygen] sats [satur @ (at) 3L/M (three I assess resident. Re	iter that resident was c/o bbing pain in left arm and o2 ations] were in the 80's on O2 iters per minute). Writer in to esident continues to c/o sharp -radiating. C/o SOB					
	(shortness of breath O2@3L/M. Resider questions. Speech pressure) 130/64, H (respiratory rate) 22	n). O2 sats 90% on nt slow to respond to writers slurred at times. B/P (blood R (heart rate) 134, RR					
	send to ER (emerge evaluation. Bed hol and sent with reside	check room) for further d policy placed in paperwork ent. Resident is her own RR entative) and aware."					
		d to reveal any evidence that f the hospital transfer was dent representative.					
	#4 (Other Staff Men #4 stated, "I do not family)." She stated	PM, in an interview with OSM nber, the social worker) OSM send a written letter (to the I that she sends written mbudsman every week of the I discharges.					
	Discharge" docume each resident to ren	ty policy, "Transfer and nted, "The facility will permit nain in the facility, and not e the resident from the facility					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· /	(X3) DATE SURVEY COMPLETED	
		495226	B. WING			C 06/07/2040	
	ROVIDER OR SUPPLIER D NURSING AND REHA			STREET ADDRESS, CITY, STATE, ZIP COD 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		06/07/2019	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 623	for the resident's we cannot be met in the have documentation record that the above The resident's attendocumentation that "b" have occurred discharges a resident resident and, if know representative of the the reasons for the residual to ensure that	sfer or discharge is necessary Ifare and the resident's needs a facility;The facility will a in the resident's medical a situations have occurred. If the facility transfers or a facility will: *Notify the a facility will: *Notify the a family member or legal a transfer or discharge and a move in writing and in a a facility critical record." If the facility clinical record." If the written notification of If the written notification of If the written notification of If the and ASM #4 (Facility Nurse It the facility Nurse It the facility is not the soft the concerns. No If the written notification of the If the facility is not the soft the concerns. No If the written notification of the or the soft the concerns. No If the facility is needed to the soft the end of the If the treat mild to moderate pain	F 62	23			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495226	B. WING		C 06/07/2019	
	ROVIDER OR SUPPLIER D NURSING AND REHA	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	1 33.01.2313	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION	
F 623	A/29/19. Resident #22 was a 11/23/12 with the didementia, atrial fibr kidney disease, Alz psychotic disorder. (Minimum Data Set with an ARD (Asses 6/3/19. The resider severely cognitively daily life decisions. A review of the clininote dated 3/11/19 Resident #22 was sfrom the wheelchair documented in part notified and gave or (emergency room) RR (resident left facility rescue squad)." A resident left facility rescue squad). "Further review of the reveal evidence that and Ombudsman we documentation of the further review of the nurse's note dated, documented the resider evaluation. The	erred to the hospital on admitted to the facility on agnoses of but not limited to illation, diabetes, chronic heimer's disease, and The most recent MDS) was an annual assessment ssment Reference Date) of hit was coded as being impaired in ability to make cal record revealed a nurse's at 9:15 a.m., that documented sent to the hospital after a fall if for evaluation. The note he, "NP (nurse practitioner) was reder to send to ER for eval (evaluation) and treat. Sentative) made aware. The top of bed hold policy are clinical record failed to he the resident representative here provided with written	F 623			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495226		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495226	B. WING		C 06/07/2019		
	ROVIDER OR SUPPLIER D NURSING AND REHAE			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	•	6/07/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 623	message for RR (res facility. 0940 (9:40 A 0945 (9:45 AM) Resi and 2 attendants. At and no answer. 1240 representative) made Further review of the reveal evidence that was provided with whospital transfer. On 6/06/19 at 7:22 P #4 (Other Staff Meml #4 stated, "I do not so family)." She stated notification to the Om recent transfers and On 6/07/19 at 7:50 A with OSM #4, she stated the Ombudsman was transfer because the the emergency room admitted to the hospithat she sent the Ommorning, 6/7/19, app the hospital transfer. On 6/6/19 at 7:43 PM Staff Member - the A Director of Nursing) a Consultant) were not	notified. 0925 (9:25 AM) left ident representative) to call IM) Rescue squad arrived. dent left facility via stretcher tempted to call report to ER O (12:40 PM) RR (resident e aware of above." clinical record failed to the resident representative itten documentation of the M, in an interview with OSM per, the social worker) OSM end a written letter (to the that she sends written abudsman every week of the	F6	23			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495226	B. WING		C 06/07/2019		
	ROVIDER OR SUPPLIER D NURSING AND REHAI	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	1 00/01/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION		
F 623	Continued From pag	e 44	F 62	3			
	written notification of provided to the resid	ailed to evidence the required fa hospital transfer was ent representative and Resident #25 was transferred 24/19.					
	7/30/18, with the dia congestive heart fail and osteoarthritis. T (Minimum Data Set) with an ARD (Assess 5/26/19. The reside	dmitted to the facility on gnoses of but not limited to, ure, dementia, depression, the most recent MDS was an annual assessment sment Reference Date) of the most coded as moderately make daily life decisions.					
	note on 5/26/19 that was sent to the hosp The note documente "Order to send to EF evaluation. RP agreres, transferred to (n	al record revealed a nurse's documented Resident #25 bital for shortness of breath. It in part the following: R (emergency room) for leable. Call made to have ame of hospital) (name of lup at 1520 (3:20 PM) via ad."					
	that the resident rep	to reveal any evidence of resentative and Ombudsman written documentation of the					
	#4 (Other Staff Mem #4 stated, "I do not s family)." She stated	PM, in an interview with OSM ber, the social worker) OSM send a written letter (to the that she sends written inbudsman every week of the discharges.					
		NM, in a follow up interview ated that for Resident #25					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495226	B. WING		C 06/07/2019		
	ROVIDER OR SUPPLIER NURSING AND REHAB	SILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	1 00/01/2013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETION		
F 623	transfer because the the emergency room admitted to the hospit that she sent the Ommorning, 6/7/19, appimonths after the hospit of the following of the sent the Ommorning, 6/7/19, appimonths after the hospimonths after t	resident was a transfer to and back, and was not tal. She provided evidence budsman notification on this roximately two and a half bital transfer. 1, ASM #1 (Administrative dministrator), ASM #2 (the and ASM #4 (Facility Nurse lified of the concerns. No as provided by the end of the uretic peptide (BNP) test is a ures levels of a protein called your heart and blood are higher than normal when experienced to treat high blood the excess water in the from ov/druginfo/meds/a682858.h	F 62	23			
	written notification of	niled to evidence the required a hospital transfer was ent representative when					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495226	B. WING		C 06/07/2040		
	ROVIDER OR SUPPLIER NURSING AND REHAI	11 1		STREET ADDRESS, CITY, STATE, ZIP COD 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		06/07/2019	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 623	2/15/19. Resident #13 was ad diagnoses of atrial fi depression, chronic disease, anxiety dischemiplegia, respirate bladder. The most reset) was a significant ARD (Assessment For The resident was coin ability to make dain the resident was ser evaluation after vomin part the following: Practitioner) notified to ER (emergency retreatment. Left messent with paperwork Further review of the reveal evidence that was provided with whospital transfer. On 6/06/19 at 7:22 Female ground the review of the reveal evidence that was provided with whospital transfer.	dmitted on 2/6/15 with the brillation, hypothyroidism, obstructive pulmonary order, intestinal obstruction, ory failure, and neurogenic ecent MDS (Minimum Data at change assessment with an deference Date) of 3/22/19. ded as moderately impaired ally life decisions. Ital record revealed a nurse at 9:00 a.m., that documented at to the hospital for iting. The note documented "FNP (Family Nurse and order received to send from for eval (evaluation) and sage for RR. Bed Hold policy to ER." In clinical record failed to the resident representative ritten documentation of the PM, in an interview with OSM ber, the social worker) OSM	F 6				
	family)." She stated notification to the Or recent transfers and On 6/6/19 at 7:43 Pt Staff Member - the A	send a written letter (to the that she sends written nbudsman every week of the discharges. M, ASM #1 (Administrative administrator), ASM #2 (the and ASM #4 (Facility Nurse					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495226	B. WING			C 06/07/2019	
	ROVIDER OR SUPPLIER NURSING AND REHAI	BILITATION CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	further information we survey. (1) Zofran - is used to vomiting. Information obtained https://medlineplus.gtml (2) Phenergan - is used and vomiting. Information obtained https://medlineplus.gtml 5. The facility staff far #15's representative notification of why the hospital on 4/11/19. Resident #15 was as 12/2/13 with the diag dementia, with behad disorder, Huntington falling. The most received the resident phaving short-term memory problems, a daily decision-makin care for hygiene, bat	tified of the concerns. No was provided by the end of the provided and control of the pro	F	623			
	noted dated 4/11/19	al record revealed a nurse's at 02:21 AM, that "observed resident on mat					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		DNSTRUCTION	(X3) DATE	SURVEY PLETED
		495226	B. WING				C / 07/2019
	ROVIDER OR SUPPLIER NURSING AND REHA			730	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW /SVILLE, VA 23947	1 00/	0112019
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 623	beside bed. no appato ER for evaluation Further review of the reveal evidence of the being provided to Re Representative for Fhospital on 4/11/19. An interview was copractical nurse) #5 casked do you give the representative anythe resident was sent to "Usually we call the going." An interview was copadimistrative staff nursing, on 6/5/19 at the facility provides representative anythey have gone to the "Not in writing, we eathern to let them know asked who notifies the stated, "The social with they go out she sends weekend, she sends On 6/7/19 at 11:48 A Member) #1, the Ad	arent injury foundWill send and treatment" e clinical record failed to be required written notification esident #15's Resident Resident #15's transfer to the resident #15's transfer to the resident #15's transfer to the resident or resident resident or resident res	F	623			
	that causes certain i waste away. People	ease: is an inherited disease nerve cells in the brain to are born with the defective s usually don't appear until					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		STRUCTION	(X3) DATE	SURVEY PLETED
		495226	B. WING				C / 07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAE	BILITATION CENTER		730 LUI	r address, city, state, zip code NENBURG HIGHW VILLE, VA 23947	1 00/	0112013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 623	middle age. Early syluncontrolled movembalance problems. Lability to walk, talk, a stop recognizing famaware of their enviro express emotions. Trom the following we https://vsearch.nlm.nmeta?v%3Aproject=1medlineplus-bundle8ase&_ga=2.1144981904618792.1557758 6. The facility staff fa #43's representative notification of why the hospital on 4/12/19, sesident #43 was ac 2/22/19 with the diag dementia with behave Alzheimer's disease, high blood pressure. (Minimum Data Set), assessment, with an date) of 5/6/19, code assessment as having problems, long-term moderate impairment A review of the clinic noted dated 4/12/19 part, "CNA (Certification urse that residen room resident notedFNP (Family Nurse)	mptoms of HD may include ents, clumsiness, and ater, HD can take away the nd swallow. Some people ily members. Others are ment and are able to this information was obtained ebsite: ih.gov/vivisimo/cgi-bin/query-medlineplus&v%3Asources= equery=huntington%27s+dise 81.349992197.1560176578-561 illed to provide Resident with the required written e resident was sent to the 5/5/19, and 5/6/19. Imitted to the facility on noses of but not limited to	F	523			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		495226	B. WING				0 7/2019
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW (EYSVILLE, VA 23947	1 00/	0112013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		(X5) COMPLETION DATE
F 623	Continued From page		F	623			
	for eval and treatmer Representative) awar to RR (resident repre	re and bed hold policy given					
	noted dated 5/5/19 at part, "Called to room	al record revealed a nurse's t 7:10 AM, documented in due to resident vomiting er received to send to ER tt"					
	noted dated 5/6/19 at part, "Resident with it	al record revealed a nurse's t 4:58 PM, documented in nspiratory expiratory wheeze onew order send to ER for					
	reveal evidence of th being provided to Re	clinical record failed to e required written notification sident #43's Resident ding transfers on 4/12/19,					
	nursing, on 6/5/19 at the facility provides the representative anything they have gone to the "Not in writing, we exthem to let them known asked who notifies the stated, "The social we they go out she sends weekend, she sends	nember) #2, the director of 2:47 p.m. When asked if the resident and/or resident ang in writing to explain why the hospital, ASM #2 stated, plain to them when we call by they are going." When the ombudsman, ASM #2 torker. If she is here the day is it, but if it happens over the					
	Member) #1, the Adn	ninistrator, was made aware orther information was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495226	B. WING			C 06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	E	00/01/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 623	Continued From pag	ge 51	F 6	23		
	#49's representative	ailed to provide Resident with the required written he resident was sent to the				
	4/23/19 with the diagraph type 2 diabetes mell heart failure, chronic disease (1), obstruct and retention of urin (Minimum Data Set) assessment, with arredate) of 5/28/19, cool 6 out of 15 on the B Mental Status) score	dmitted to the facility on gnoses of but not limited to litus, high blood pressure, c obstructive pulmonary tive and reflux uropathy (2), le. The most recent MDS of a 14-day Medicare of ARD (Assessment reference ded the resident as scoring a lMS (Brief Interview for le, indicating the Resident had coairment for daily decision				
	note dated 5/12/19 a part, "No acute char Practitioner) aware	cal record revealed a nurse's at 9:16 PM, documented in ages. (Name of) NP (Nurse of resident's complaints of a order to transport to ER"				
	reveal evidence of the being provided to Re	e clinical record failed to he required written notification esident #49's Resident arding transfers on 5/12/19.				
	nursing, on 6/5/19 a the facility provides representative anyth	nducted with ASM member) #2, the director of t 2:47 p.m. When asked if the resident and/or resident ning in writing to explain why ne hospital, ASM #2 stated,				

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		495226	B. WING _			C 06/07/2019
	ROVIDER OR SUPPLIER D NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	•	00/07/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 623	"Not in writing, we e them to let them knd asked who notifies t stated, "The social withey go out she sends weekend, she sends on 6/7/19 at 11:48 A Member) #1, the Ad of the findings. No f provided by the end (1) Chronic obstruct Disease that makes lead to shortness of obtained from the whittps://www.nlm.nih. (2) Obstructive and uropathy is a condition is blocked. This causinjure one or both kin obtained from the weekend in the weekend in the send of the se	xplain to them when we call by they are going." When the ombudsman, ASM #2 worker. If she is here the day ds it, but if it happens over the sit Monday morning." AM, ASM (Administrative Staff ministrator, was made aware further information was of the survey. Ive pulmonary disease: it difficult to breath that can breath. This information was ebsite: gov/medlineplus/copd.html. reflux uropathy: Obstructive on in which the flow of urine ses the urine to back up and dneys. This information was	F 6	23		
	#46's representative notification of why the hospital on 5/28/19.	ailed to provide Resident with the required written he resident was sent to the				
	on9/18/17 with the of high blood pressure chronic obstructive pasthma. The most r Set), a five-day Med ARD (Assessment re	dmitted to the facility liagnoses of but not limited to , heart attack, heart failure, bulmonary disease (1), and recent MDS (Minimum Data licare assessment, with an reference date) of 5/17/19, as scoring a 13 out of 15 on				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY
		495226	B. WING				07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAE	BILITATION CENTER		73	REET ADDRESS, CITY, STATE, ZIP CODE O LUNENBURG HIGHW EYSVILLE, VA 23947	1 00	0112013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 623	Continued From page the BIMS (Brief Interscore, indicating the impairment for daily of A review of the clinica note dated 5/28/19 a part, "order receive Practitioner) to send eval and treatment A review of the clinica physician's note dated 5/28/19 at documented in part, (name of) Hospital 5/28/19 in" Further review of the reveal evidence of the being provided to the Representative regard hospital on 5/28/19. An interview was corrected administrative staff in nursing, on 6/5/19 at the facility provides the representative anything the solution of the staff in the facility provides the representative anything the solution of the solution of the staff in the facility provides the representative anything the solution of the soluti	view for Mental Status) Resident had no cognitive decision making. al record revealed a nurse's ta:44 AM, documented in ed from FNP (Family Nurse to ER (Emergency room) for al record revealed a state of 5/20/19 at 8:45 PM, She was hospitalized at 1/28/19 - 6/3/19 for abdominal clinical record failed to e required written notification explain the transfer to the state of 2:47 p.m. When asked if the resident and/or resident ing in writing to explain why		623			
	"Not in writing, we ex them to let them known asked who notifies the stated, "The social we they go out she sends weekend, she sends On 6/7/19 at 11:48 A Member) #1, the Adm	M, ASM (Administrative Staff ninistrator, was made aware urther information was					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		ATE SURVEY DMPLETED
		495226	B. WING _			C 06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		50/07/2015
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 623	Disease that makes lead to shortness of obtained from the whttps://www.nlm.nih. 9. The facility staff fa and/or the resident in notification as to the transferred to the hor #19. Resident #19 was a 1/5/17 with a recent diagnoses that includiabetes, high blood falls and anemia (chemoglobin content limits) (1). The most recent MD assessment, a quarassessment, a quarassessment referen resident as scoring a interview for mental resident was severe cognitive decisions.	ive pulmonary disease: it difficult to breath that can breath. This information was	F 6	, , , , , , , , , , , , , , , , , , ,		
	observed resident o beside his bed. He t to stand from wheel completedNeurolo he did not hit his he pain in right abdome of 1-10 and complai (nurse practitioner)	n floor laying on his right side ells nurse that he was trying chair. Nursing assessment egical assessment, tells nurse ead. Resident complains of en rating 9 on the pain scale ens of shoulder pain. NP made aware with orders to ency room) for evaluation.				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		OMPLETED
		495226	B. WING _			C 06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		00/07/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 623	RR (resident repres report called to ER at The physician's order "Send to ER for eval post fall)." An interview was conpractical nurse) #5 or asked if she or anyon written notification to representative of the going to the hospital, usually call then and and document it in the An interview was constaff member (ASM) and 6/5/19 at 2:47 p.m resident and/or the R why they went to the "Not in writing, we exwhen we call them." Administrative staff mand ASM #4, the facil made aware of the at 7:35 p.m.	ducted with LPN (licensed n 6/5/19 at 2:37 p.m. When ie in the facility provides the resident and/or resident reason why the resident is LPN #5 stated, "No, we tell them why they are going	F 6	23		
F 625 SS=E	Non-Medical Reader, Chapman, page 33. Notice of Bed Hold Po CFR(s): 483.15(d)(1)	5th edition, Rothenberg and olicy Before/Upon Trnsfr	F 6	25		7/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495226	B. WING _			C 06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHA	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	!	00/01/2013
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOU		SHOULD BE	(X5) COMPLETION DATE
F 625	Continued From pa	ge 56	F 6	25		
	nursing facility trans the resident goes o nursing facility mus the resident or resid specifies- (i) The duration of t any, during which the return and resume facility; (ii) The reserve bed plan, under § 447.4 (iii) The nursing face bed-hold periods, w paragraph (e)(1) of resident to return; a (iv) The information of this section. §483.15(d)(2) Bed- the time of transfer hospitalization or the facility must provide resident representa specifies the duration described in paragr This REQUIREMEN by: Based on staff inte review, and clinical determined that the that a written bed h resident and/or resi manner for seven of	n specified in paragraph (e)(1) hold notice upon transfer. At		F-625 Notification of our bed Hold poprovided to Resident #□ 41, 2: 43, 49, and 46 and also to their Representative. A review of unplanned dischar previous 30 days was conduct issues were found. Licensed Nursing Staff will be on the Bed hold Policy and the	2, 13, 15, ir Resident ges for the ted and no in-serviced	

_ ` · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		405226	B. WING	_		(
		495226	B. WING _			06/	07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	hold notice was provirepresentative when transferred to the hose Resident #41 was ad 7/10/18 with the diagracute respiratory failupressure, anxiety disorder, atrial fibrillat chronic obstructive pure osteoporosis. The moderate of the moderate of the moderate of the clinical following nurses note "Therapy alerted write (complaining of) stable [oxygen] sats [saturated] (at) 3L/M (three lite assess resident. Respin in left arm, non-respiratory some of the clinical following nurses note "Therapy alerted write (complaining of) stable [oxygen] sats [saturated] (at) 3L/M (three lite assess resident. Respin in left arm, non-respiratory some of the clinical following nurses of breath). O2@3L/M. Resident questions. Speech signerssure) 130/64, HR (respiratory rate) 22. Practitioner) made av send to ER (emergene evaluation. Bed hold	illed to evidence that a bed ded to the resident Resident #41 was spital on 4/29/19. mitted to the facility on noses of but not limited to, are, diabetes, high blood order, breast cancer, bladder cion, congestive heart failure, almonary disease, and ost recent MDS (Minimum ficant change assessment ment Reference Date) of was coded as being in ability to make daily life all record revealed the : 4/16/19 at 3:39 PM: er that resident was c/o bing pain in left arm and o2 cions] were in the 80's on O2 ers per minute). Writer in to sident continues to c/o sharp radiating. C/o SOB O2 sats 90% on slow to respond to writers all urred at times. B/P (blood to the continue of the continue	F	525	requirement that it be included in the transfer packet. The Cardinal IDT members will review unplanned discharges in its morning meeting to ensure compliance. The Social worker will maintain a log that verifies and ensures that the Resident and Resider Representative received proper notification of the Bed Hold Policy. The unplanned Discharges log will be reviewed weekly for compliance with proper notifications and results of the reviews submitted to the facility SQAF Committee at its monthly meeting.	t	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495226	B. WING		C 06/07/2019
	ROVIDER OR SUPPLIER O NURSING AND REHA	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	, 000.720.10
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUTH CONTROL TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 625	Continued From pa	ge 58	F 625	5	
		e clinical record failed to it the resident representative he written bed hold			
	practical nurse) #5 regarding the facilit resident is sent to the where do you docu	onducted with LPN (licensed on 6/5/19 at 2:37 p.m., y process for bed hold when a he hospital. When asked ment what was sent to the ated, "We write a note about			
	Discharge" reveale	lity policy, "Transfer and d the policy did not include any sion of a written bed hold			
	Staff Member - the Director of Nursing) Consultant) were no	PM, ASM #1 (Administrative Administrator), ASM #2 (the and ASM #4 (Facility Nurse otified of the concerns. No was provided by the end of the			
	hold notice was pro	failed to evidence that a bed vided to the resident n Resident #25 was ospital on 3/24/19.			
	7/30/18, with the diacongestive heart fa and osteoarthritis. (Minimum Data Set with an ARD (Asset 5/26/19. The reside	admitted to the facility on agnoses of but not limited to, illure, dementia, depression, The most recent MDS) was an annual assessment assment Reference Date) of ent was coded as moderately on make daily life decisions.			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		495226	B. WING _			C 06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	<u> </u>	00/07/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 625	note on 5/26/19 that was sent to the hosp The note documente "Order to send to ER evaluation. RP agreeres, transferred to (natown). Res. picked u (county) rescue square Further review of the reveal evidence that was provided with the notification. An interview was compractical nurse) #5 or regarding the facility resident is sent to the where do you docum hospital, LPN #5 statt the bed hold." On 6/6/19 at 7:43 PM Staff Member - the ADirector of Nursing) a Consultant) were not further information was survey. (1) BNP - Brain natriblood test that measus BPN that is made by	al record revealed a nurse's documented Resident #25 ital for shortness of breath. Ital for shor	F 6	25		

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.		1 1	IPLE CONSTRUCTION NG	' '	(X3) DATE SURVEY COMPLETED		
		495226	B. WING _			C 06/07/2019	
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 625	(2) Lasix - is a diuretic pressure by reducing body. Information obtained https://medlineplus.grtml (3) Levaquin - is an a Information obtained https://medlineplus.grtml 3. The facility staff fahold notice was proving representative when transferred to the host representative when transferred to the most representative when transferred to the most representative when transferred to the most representative when transferred to the host representative when tr	c used to treat high blood the excess water in the from by/druginfo/meds/a682858.h Intibiotic. from by/druginfo/meds/a697040.h Intibiotic. from by/druginfo/meds/a697040.h Intibiotic.	Fé	325			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495226	B. WING			06/) 07/2019	
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CIT 730 LUNENBURG HIG KEYSVILLE, VA 23	SHW	1 00/	0772019	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CC	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD B FERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 625	Further review of the reveal evidence that was provided with the within the required 2 hospital transfer. The hold notice being progresident was transfer. An interview was compractical nurse) #5 compractica	e clinical record failed to the resident representative are written bed hold notification 4-hour time frame of the are note documenting the bed ovided was 7 days after the rred. Inducted with LPN (licensed on 6/5/19 at 2:37 p.m., process for bed hold when a e hospital. When asked ment what was sent to the ted, "We write a note about M, ASM #1 (Administrative administrator), ASM #2 (the and ASM #4 (Facility Nurse tified of the concerns. No was provided by the end of the concerns and from gov/druginfo/meds/a601209.h	F	525				
	#15's representative	ailed to provide Resident written notification of the bed e required timeframe when						

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		` '	LE CONSTRUCTION		COMPLETED		
		495226	B. WING			C 06/07/2019	
	ROVIDER OR SUPPLIER NURSING AND REHAE	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 625	the resident was tran 4/11/19. Resident #15 was ad 12/2/13 with the diag dementia, with behave disorder, Huntington' falling. The most received the resident per having short-term memory problems, at daily decision-making. A review of the clinica noted dated 4/11/19 documented in part, beside bed. no appart to ER for evaluation at Eurther review of the reveal evidence of the of the bed hold policy timeframe when the inthe hospital on 4/11/2. An interview was compractical nurse) #5 or regarding the facility resident is sent to the where do you documented on the process of the process of the sent to the where do you documented on the process of the process o	mitted to the facility on noses of but not limited to rioral disturbances, anxiety is disease (1) and history of ent MDS (Minimum Data dicare assessment, with an ference date) of 4/3/19, er staff assessment as emory problems, long-term and severe impairment of 3. all record revealed a nurse's eat 02:21 AM, that 'observed resident on mat rent injury foundWill send and treatment" clinical record failed to be required written notification of within the required resident was transferred to 19. ducted with LPN (licensed)	F 62	,			
	Member) #1, the Adn	M, ASM (Administrative Staff ninistrator, was made aware arther information was of the survey.					

AND DUAN OF CORDECTION		` '	PLE CONSTRUCTION G	COMPL	(X3) DATE SURVEY COMPLETED		
		495226	B. WING		06/) 7/2019	
	ROVIDER OR SUPPLIER NURSING AND REHAE	l		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 625	that causes certain n waste away. People gene, but symptoms middle age. Early synuncontrolled moveme balance problems. Lability to walk, talk, a stop recognizing fam aware of their environ express emotions. T from the following we https://vsearch.nlm.nmeta?v%3Aproject=rmedlineplus-bundle&	ase: is an inherited disease erve cells in the brain to are born with the defective usually don't appear until apptoms of HD may include ents, clumsiness, and ater, HD can take away the nd swallow. Some people ily members. Others are ament and are able to his information was obtained	F 62	25			
	#43's representative hold policy within the the resident was tran 5/5/19, and 5/6/19. Resident #43 was ac 2/22/19 with the diag dementia with behav Alzheimer's disease, high blood pressure. (Minimum Data Set), assessment, with an date) of 5/6/19, code assessment as having problems, long-term	iled to provide Resident written notification of the bed required timeframe when sferred to the hospital on mitted to the facility on noses of but not limited to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495226	B. WING			C 6/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAE			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		6/07/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 625	noted dated 5/5/19 ar part, "Called to roomcalled FNP (family received to send to E eval (evaluation) and A review of the clinica noted dated 5/6/19 ar part, "Resident with ircalled (name of) NI [emergency room] for Further review of the reveal evidence of the of the bed hold policy timeframe for Reside and 5/6/19. An interview was compractical nurse) #5 or regarding the facility resident is sent to the where do you docum hospital, LPN #5 statt the bed hold." On 6/7/19 at 11:48 A Member) #1, the Adnof the findings. No further provided by the end of 6. The facility staff fail	al record revealed a nurse's to 7:10 AM, documented in due to resident vomiting nurse practitioner) and order (R (emergency room) for treatment" al record revealed a nurse's to 4:58 PM, documented in espiratory expiratory wheeze one order send to ER revaluation." clinical record failed to erequired written notification or within the required ent #43's transfers on 5/5/19, and to the edd of 6/5/19 at 2:37 p.m., process for bed hold when a exposition. When asked ent what was sent to the edd, "We write a note about either information was of the survey.	F 6	25		
	hold policy within the	written notification of the bed required timeframe when sferred to the hospital on				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495226	B. WING			C 06/07/2019
	ROVIDER OR SUPPLIER D NURSING AND REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	•	00/07/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCEI	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 625	Resident #49 was ac 4/23/19 with the diag type 2 diabetes melli heart failure, chronic disease (1), obstruct and retention of urine (Minimum Data Set), assessment, with an date) of 5/28/19, cod 6 out of 15 on the BI Mental Status) score severe cognitive improved making. A review of the clinic note dated 5/12/19 a part, "No acute chan Practitioner) aware of chest pain and gave (Emergency room) Further review of the reveal evidence of the of the bed hold policy timeframe for Reside 5/12/19. An interview was corpractical nurse) #5 or regarding the facility resident is sent to the where do you docum hospital, LPN #5 stat the bed hold." On 6/7/19 at 11:48 A Member) #1, the Adr	dmitted to the facility on thoses of but not limited to tus, high blood pressure, obstructive pulmonary live and reflux uropathy (2), e. The most recent MDS a 14-day Medicare ARD (Assessment reference ed the resident as scoring a MS (Brief Interview for a indicating the Resident had airment for daily decision all record revealed a nurse's to 9:16 PM, documented in ges. (Name of) NP (Nurse of resident's complaints of order to transport to ER." The clinical record failed to the required written notification by within the required ent #49's transfers on and the complete of the end of 5/19 at 2:37 p.m., process for bed hold when a de hospital. When asked the ent what was sent to the led, "We write a note about the end, "We write a note about with the information was a made aware further information was	F	525		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	(X3) DATE SURVEY COMPLETED	
495226 B. WING	C 06/07/2019	
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	00/01/2013	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
(1) Chronic obstructive pulmonary disease: Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (2) Obstructive and reflux uropathy: Obstructive uropathy is a condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys. This information was obtained from the website: https://medlineplus.gov/ency/article/000507.htm 7. The facility staff failed to provide Resident #46's representative written notification of the bed hold policy when the resident was transferred to the hospital on 5/28/19. Resident #46 was admitted to the facility on9/18/17 with the diagnoses of but not limited to high blood pressure, heart attack, heart failure, chronic obstructive pulmonary disease (1), and asthma. The most recent MDS (Minimum Data Set), a five-day Medicare assessment, with an ARD (Assessment reference date) of 5/17/19, coded the resident as scoring a 13 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had no cognitive impairment for daily decision making. A review of the clinical record revealed a nurse 's note dated 5/28/19 at 8.44 AM, documented in part, "order received from FNP (Family Nurse Practitioner) to send to ER (Emergency room) for		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	(X3) DATE SURVEY COMPLETED		
		495226	B. WING		C 06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	000072013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 625	F 625 Continued From page 67 Further review of the clinical record failed to reveal evidence of the required written notification		F 62	25	
	of the bed hold policy timeframe of Residen hospital on 5/28/19.	within the required t #46's transfer to the			
	practical nurse) #5 or regarding the facility president is sent to the where do you docume	ducted with LPN (licensed n 6/5/19 at 2:37 p.m., process for bed hold when a hospital. When asked ent what was sent to the ed, "We write a note about			
	Disease that makes it lead to shortness of b obtained from the we https://www.nlm.nih.g	ov/medlineplus/copd.html.	F 64	41	7/21/19
	resident's status. This REQUIREMENT by: Based on staff interv and clinical record refacility staff failed to eaccurate MDS (minim	of Assessments. It accurately reflect the is not met as evidenced liew facility document review view, it was determined the ensure a complete and hum data set) assessment is in the survey sample,		F-641 The MDS for Resident #27 was correct and updated during the survey. No other assessments in Section C w found to be incorrect.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495226	B. WING			1	C (07/2040
NAME OF PI	ROVIDER OR SUPPLIER	100220	<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 06/	/07/2019
WAYLAND	NURSING AND REHAB	ILITATION CENTER		7	30 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From page	e 68	F	341			
	Resident #27.				An in-service training for the Social Worker was conducted by the Facility		
	The findings include:				MDS nurse to educate the SS on the proper coding for Section C of the MDS	S.	
	·	I to accurately code Section			The MDS nurse will oversee the coding	g	
		essment with an ARD ce date) of 4/29/19, the			efforts of the Social Worker to ensure the coding is accurate and complete. A		
	annual assessment w	vith an ARD of 1/28/19 and			non- compliance will result in further	,	
	the quarterly assessn 10/31/18 for Resident				education and training.		
		mitted to the facility on					
	1/31/04 with diagnose limited to: stroke, dep	es that included but were not ression, high blood					
	pressure and Parkins	on's Disease (a slowly					
	,	ical disorder characterized uffling gait, stooped posture,					
	_	fingers, drooling and muscle					
	weakness, sometime (1).	s with emotional instability)					
	The most recent MDS	6 (minimum data set)					
		erly assessment, with an					
	Hearing, Speech and	ed the resident in Section B - Vision as sometimes					
	making himself under	stood and usually					
	understanding others Patterns, the resident	. In Section C - Cognitive					
		interview was not interview was completed.					
	The resident was cod	ed as having both short and					
		ficulties and was coded as					
	cognitive decisions, s	pendence in making daily come difficulty in new					
	situations only.	amounty in now					
	The annual assessme	ent, with an ARD of 1/28/19,					
		s sometimes making himself					
		lly understanding others. In					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495226	B. WING _			C 06/07/2019	
	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA	DATE	
F 641	interview was not cowas completed. The having both short and difficulties and was condependence in masome difficulty in new The quarterly assess 10/31/19, coded the Hearing, Speech an making himself understanding other Patterns, the resider completed. The staff The resident was colong-term memory of the having modified indecognitive decisions, situations only. The instructions on the Section C - Cognitive "Should Brief Intervice Conducted? Attempresidents. Code: 0. If understood) - skip to C0700-C1000, Staff Status. Code 1. Yes Repetition of Three Coded on all three Memory and the Section BIMS (brief interview Enter 99 if the resident the interview."	re Patterns, the resident ampleted. The staff interview resident was coded as ad long-term memory coded as having modified aking daily cognitive decisions, we situations only. Sment, with an ARD of resident in Section B - d Vision as sometimes erstood and usually so. In Section C - Cognitive at interview was not afficulties and was coded as expendence in making daily some difficulty in new to conduct interview with all No (resident is rarely/never	F	541			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B. WING				07/2019
	ROVIDER OR SUPPLIER D NURSING AND REHA	BILITATION CENTER		730	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW YSVILLE, VA 23947	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 641	C of the MDS asses social worker. When Section B, RN #1 sta RN #1 was asked to assessment in Secti stated, "It (the interview was completed. He is not an interview was commember) #4, the soci p.m. When asked if completing Section Ma'am." The above C were reviewed wit "When I ask him the "bowlly ball." When a facility uses to composm #4 stated, "The instrument) manual." The facility document documented in part, 0, no: if the interview because the resident cannot respond verbinterpreter is needed yes: if the interview sthe resident is at leaverbally or in writing needed, one is avail stopped, do the follo C0400A, C0400B, a summary score in C C0600 Should the S Status be Conducted Assessment for Meritages.	sked who completes Section sments, RN #1 stated the asked who completes ated that she did Section B. review the above MDS on B and Section C. RN #1 iew) should have been a rarely/never understood. Inducted with OSM (other staff itial worker, on 6/5/19 at 2:01 she reads Section B prior to C. OSM #4 stated, "No, MDS assessments, Section in OSM #4. OSM #4 stated, questions he only replies asked which reference the lete the MDS assessments, e RAI (resident assessment in resident assessment in the RAI manual, "Coding Instructions- Code in should not be attempted it is rarely/never understood, ally or in writing, or an in but not available. Code1, should be attempted because its sometimes understood and if an interpreter is ableIf the interview is wing: 1. Code -, dash in and Co400C. 2. Code 99 in the 0500. 3. Code 1, yes, in taff Assessment for Mental 17. 4. Complete the Staff	F	541			

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495226	B. WING _		C 06/07/2019	
	ROVIDER OR SUPPLIER D NURSING AND REHAE	ı		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 641	consultant, were mad findings on 6/6/19 at No further informatio (1) Barron's Dictiona	SM #4, the facility nurse de aware of the above	F 6	41		
	S483.21(b) (1) §483.21(b) Compreh §483.21(b) (1) The fa implement a compreicare plan for each re resident rights set for §483.10(c)(3), that in objectives and timefr medical, nursing, and needs that are identifiassessment. The cordescribe the following (i) The services that or maintain the residiphysical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the runder §483.10, includer §483.10, includer §483.10 and services provide as a result of recommendations. If	ensive Care Plans cility must develop and hensive person-centered sident, consistent with the rth at §483.10(c)(2) and heliudes measurable ames to meet a resident's dimental and psychosocial fied in the comprehensive mprehensive care plan must g - are to be furnished to attain ent's highest practicable di psychosocial well-being as .24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 3.10(c)(6). services or specialized s the nursing facility will f PASARR a facility disagrees with the RR, it must indicate its	F 6	56	7/21/19	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B. WING _			C 06/07/2019	
	ROVIDER OR SUPPLIER O NURSING AND REHA	ABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CO 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		9.01.2010	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 656	resident's represent (A) The resident's of desired outcomes. (B) The resident's putture discharge. F whether the reside community was as local contact agence entities, for this purities, for this puritie	with the resident and the stative(s)-goals for admission and preference and potential for acilities must document int's desire to return to the sessed and any referrals to cies and/or other appropriate rose. In accordance with the porth in paragraph (c) of this in the series and record review, it is facility staff failed to implement the care appropriate to the failed to implement the care psychotropic medications for failed to implement the care psychotropic medications for failed to implement the care psychotropic medications for failed to implement the care failed to implement the care psychotropic medications for failed to implement the care	F 6	F-656 Staff were in-serviced on the for resident #s 33, 34, 44, 1 14. The education emphasize for care plan compliance for blood pressure medication, medication, and antipsychomedications. Results of further observation further care plan non-consuring staff members will monthly in-services on the replans to ensure continued of also to be aware of any care or changes. The Director of Nursing or him will conduct weekly checks that care plans are being for results of the checks will be the Cardinal IDT meetings a submitted to the facility QAI	10, 49, 48, and zed the need or pain, oxygen, psychotropic otic ons indicated impliance. receive resident care compliance and re plan updates to determine officed. The ediscussed in and results		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495226	B. WING			C 06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHA	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	•	00/07/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	F 656 Continued From page 73		F 6	56		
	·	railed to implement the e plan for the administration of the #10.				
		ailed to implement the e plan for the administration of the table.				
	·	failed to implement the e plan for the administration of the #48.				
	comprehensive car	failed to implement the e plan for the use of ation for Resident #14.				
	The findings include	e:				
		failed to implement the care ent of high blood pressure for				
	5/1/19 with diagnos limited to: dementia diabetes, stroke an pulmonary disease nonreversible lung	admitted to the facility on less that included but were not an high blood pressure, do COPD (chronic obstructive general term for chronic, disease that is usually a sobysema and chronic				
	assessment, an add assessment referer resident as scoring interview for menta is severely impaired	DS (minimum data set) mission assessment, with an ace date of 5/8/19, coded the a "3" on the BIMS (brief I status) score, indication she d to make daily cognitive dent was coded as requiring				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION 3		(X3) DATE SURVEY COMPLETED	
		495226	B. WING			C 06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	•	7570172013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	F 656 Continued From page 74		F 6	56		
		e to being dependent upon r all of her activities of daily				
	documented in part, blood pressure): at I failure, arteriosclero retinopathy." The "Ir	nterventions" documented in pressure per facility protocol				
	"Metoprolol Tartrate pressure) (2), 25 mg by mouth twice daily	dated, 5/2/19 documented, (used to treat high blood g (milligrams) 1/2 = 12.5 mg //. Hold for SBP (systolic blood 100 or HR (heart rate) less				
	documented the abor following dates and pressure/pulse was administration of the 5/8/19 at 9:00 a.m. 5/8/19 at 9:00 p.m. 5/10/19 at 9:00 p.m. 5/12/19 at 9:00 p.m. 5/12/19 at 9:00 p.m. 5/16/19 at 9:00 p.m. 5/20/19 at 9:00 p.m. 5/21/19 at 9:00 p.m. 5/21/19 at 9:00 p.m. 5/22/19 at 9:00 p.m. 5/22/19 at 9:00 p.m. 5/22/19 at 9:00 p.m. 5/23/19 at 9:00 p.m.	dication administration record) ove medication. On the time, the following blood not documented prior to the e medication: - no pulse was documented - no blood pressure or pulse - no pulse was documented				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495226	B. WING		06/07/2019	
	ROVIDER OR SUPPLIER D NURSING AND REHA	ABILITATION CENTER	;	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	1 00.01.2010	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION	
F 656	5/26/19 at 9:00 a.m 5/26/19 at 9:00 p.m was documented 5/28/19 at 9:00 p.m was documented 5/29/19 at 9:00 p.m was documented 5/30/19 at 9:00 p.m was documented. Review of the nurse dates and times fair of the missing bloom the vital signs tab in failed to evidence the pressure readings. An interview was concerned as a sked to read when asked if a rest the nurse to do LPM the blood pressure when asked if the medications as ord plan, LPN #2 stated. An interview was constaff member (ASM on 6/5/19 at 3:36 plabove order. When supposed to do, AS pressure and pulsed documentation of a size of the size of the supposed to do, AS pressure and pulsed documentation of a size of the size of	a no pulse was documented b no pulse was documented c no pulse or blood pressure c no blood pressure or pulse c no blood pressure or pulse c no blood pressure or pulse c no pulse was documented c no pulse or blood pressure ce's notes for the above listed cled to evidence documentation d pressure or pulse. Review of control the computerized record, conducted with LPN (licensed con 6/5/19 at 3:29 p.m. LPN #2 control that that order, what is control that that order, what is control take both, LPN #2 control take both that following the care	F 656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 656	Continued From pag	ge 76	F 6	56		
	say 'or." .When aske	ed if the care plan says to give ered, and it's not given as wing the care plan, ASM #2				
	to provide a written based upon physicia assessment of the r	"It is the policy of the facility resident-centered care plan an's orders, and the esident needs and				
	of the resident's car participating discipli	nes available in the facility at under the director of the RN				
		strator and ASM #4, the tant, were made aware of the /6/19 at 7:45 a.m.				
	No further information	on was obtained prior to exit.				
	Non-Medical Reade Chapman, page 124 (2) This information following website:	ary of Medical Terms for the r, 5th edition, Rothenberg and 4. was obtained from the gov/druginfo/meds/a682864.h				
		failed to implement the care sychotropic medications for				
	10/17/17 with diagn not limited to: diabe stroke, high blood p	dmitted to the facility on oses that included but were tes, dementia, depression, ressure, and bradycardia (A er than 60 in adults) (1).				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495226	B. WING_			C 06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP COD 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	•	00/07/2019
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 656	assessment reference resident as scoring "3 interview for mental stresident was severely cognitive decisions. It resident was not code during the look back psychosis. The comprehensive of documented in part, "in which resident acts coping; verbal/physic combativeness relate "Interventions" document behavior (pfacility protocol." The documented, "Focus: which resident acts of coping; Sleeplessness restlessness." The "Ir part, "Administer mediate pattern and quality of episodes, and notify possible interventions plan documented "Fodrugs with the POTEI by SIDE EFFECTS of gastrointestinal syste or/due to diagnoses of antidepressant (GDR antipsychotic 7/6/18.) documented, "Administred."	S (minimum data set) erly assessment, with an e date of 5/10/19, coded the strong the BIMS (brief tatus) score, indicating the or impaired to make daily in Section E - Behaviors, the ed as having any behaviors beriod and not indicators of stare plan dated, 10/22/18 Focus: Problematic manner of characterized by ineffective all aggression or d to: anger." The mented in part, "Monitor and ohysical behaviors) per care plan further Problematic manner in haracterized by ineffective sylinsomnia related to: nterventions" documented in dication. Monitor sleep sleep/rest, document ohysician of changes for as a appropriate." The care cus: Use of psychoactive NTIAL FOR or characterized f cardiac, neuromuscular, ms AEB (as exhibited by) of: antipsychotic, [gradual dose reduction] " The "Interventions" ster medications per observe resident's mental	F	656		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER D NURSING AND REHA			STREET ADDRESS, CITY, STATE, ZIP CO 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		30/07/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 656	through 6/6/19, failed documentation relations sleep patterns. The review of the nuthrough 6/6/19 docubehaviors: "1/25/19 at 2:40 p.m (resident representates resident's feet. Areathe cream however it to be put on. "2/2/19 at 10:45 p.m memory loss. Wantseats supper. Staff if that we are in the mother residents. Resiminutes later will be wants to go to bed. and drinks from hon supper. "2/13/19 at 2:51 p.m RR about resident in stated that she had facility, use what is "2/26/19 at 11:52 a. no BM (bowel move administer MOM (mostated, "I'm not takin refuse. "3/6/19 at 2:38 p.m.	inical record from 12/1/18 Ind to evidence any ed to any physical behavior or arse's notes from 12/1/19 Imented the following In message left for RR Intive) regarding condition of seremain dry continuing with the frequently refused to allow In., Resident has short term to go to bed as soon as he has to remind him every night iddle of supper ad feeding sident will say OK, then a few calling for help. Is saying he wife brings him snack food the, which he eats before In. Nurse called and spoke with efusal with shaving. She already brought razor up to	F 68	56			
	assistant) resident r morning, writer offer "3/15/19 at 10:06 a.	Per CNA (certified nursing efused to be shaved this red to so still resident refused. m. Flagging x3 days no BM. administer MOM and resident					

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	ROVIDER OR SUPPLIER NURSING AND REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	•	00/07/2013
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 656	refused. "3/30/19 at 8:41 a.m." "4/8/19 at 12:02 p.m. x 3 days, would only [milliliters]) of MOM of "4/8/19 at 7:00 p.m. to be lifted by CNA wasupervision. "4/18/19 at 2:08 p.m. x 3 days, resident or centimeters) MOM. "4/22/19 at 11:08 a.m. BM x3 days, resident protocol. "4/24/19 at 5:52 a.m. bowel movement in tarefusal of MOM. "5/15/19 at 5:51 a.m. x3 days, MOM refuse "5/17/19 at 10:29 a.m.	, Resident refused shower. resident flagging for no BM accept half (15 ml of 30 ml dose. REFUSAL - resident refused r/lift (with lift) under direct resident flagging for no BM only accepted 15 cc (cubic on., Resident flagged for no other refused to take MOM per Resident flagging for no one past three days. Due to Resident flagging for no BM one. Resident flagging for no BM one. Resident flagging for no BM one. Resident flagging for no bit resident flagging for no given but resident would only	Fé	656		
	in part, "Psych (psyc understand who I am documentation regar The physician note d evidence documenta behaviors.	dated 11/26/18, documented hiatric): he is pleasant and a as the doctor. No other ding his mood or behaviors. ated, 12/3/18, failed to tion related to mood or ated, 4/1/19, failed to entation related to mood or				
	The nurse practitions	er note dated, 12/5/18, "Past Medical History -				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		495226	B. WING			C 06/07/2019
	ROVIDER OR SUPPLIER D NURSING AND REHAE	1		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	I	06/07/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	, ,	e 80 of Systems: Psychiatric - no	F 6	56		
		ess or suicidal ideations. chiatric: no increased				
	documented in part, depression. Review mood swings, increa ideations. Physical E	er note dated, 2/22/19, "Past Medical History - of Systems: Psychiatric - no sed nervousness or suicidal exam: Psychiatric - Mood and lent oriented to person and				
	documented in part, compliance with his (Resident #34) has c irritability, mood swir motivation. She report medication and coop denies any suicidal ideationsPast Med Review of Systems: cognition or increase	orts he is compliant with his berative with his care. He deations or homicidal ical History - Depression. Psychiatric: no changes in ed nervousnessPhysical flood and affect flat; resident				
	practical nurse) #2 o asked where behavior stated, on the back of administration record. When asked what Robehaviors are for the stated, "When he first been cut back. His whelp him sleep. Latel improved." When as	nducted with LPN (Licensed n 6/5/19 at 5:43 p.m. When ors are documented, LPN #2 of the MAR (medication d) and in the progress notes." esident #34's targeted use of Seroquel, LPN #2 of came he was on it but it's wife said he took it at home to by his behaviors are much ked when she would r, LPN #2 stated she's				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG	` '	(X3) DATE SURVEY COMPLETED	
		495226	B. WING _			C 06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		00/07/2013
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	behavior or something When asked if documpatterns are on the coare plan, LPN #2 since we don't usually document if they have document if they have document if they have document if they have asked they are a since we will be a since with an assessment and they are the resident was capable of the resident was	aw the resident having a ng that is out of their norm." menting behaviors and sleep care plan, is that following the tated, "I guess not because nument on sleep patterns, just we problems sleeping." Strator, ASM #2, the director #4, the facility nurse de aware of the above to 7:35 p.m. On was provided prior to exit. Ary of Medical Terms for the resident #44. OS (minimum data set) ficant change assessment, reference date of 5/16/19, as scoring a "14" on the BIMS mental status) score, indicating bable of making daily The resident was coded as assistance of one staff her activities of daily living. In onditions, the resident was as not having been observed	F 6	56		
	of pain or facial grim	erbal signs, vocal complaints acing indicating pain. The as not having documentation				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER D NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	•	00/07/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	revised on 5/20/19, Risk for Potential P impaired mobility, h bilateral knees, fem (stroke)." The "Inter "Administer pain moorders and note the needed) meds (med pain as per MD ord effectiveness. Mon characteristics of pa frequency, precipital The physician order "Ultram (Tramadol) moderately severe 1 by mouth three tir The May 2019 MAF record) documented Tramadol. The med having been administrated times: 5/16/19 at 6:00 a.m documented. 5/16/19 at 10:00 p.r documented 5/19/19 at 11:45 p.m documented 5/20/19 at 3:15 p.m 5/21/19 at 2:15 a.m 5/27/19 at 4:45 p.m 5/28/19 at 8:40 a.m 5/29/19 at 4:30 p.m None of the above of the severe service of the severe sev	care plan dated, 1/16/17 and documented in part, "Focus: ain, chronic related to x (history of) osteoarthritis, ur, right arm pain and CVA ventions" documented in part, edication as per MD (doctor) reffectiveness. Give PRN (as dications) for breakthrough ers and note the itor and document ain: location, severity and ting factors, etc." If dated, 5/15/19, documented, (used to treat moderate to pain) (3), 50 mg (milligrams), mes a day as needed for pain." R (medication administration define above order for lication was documented as stered on the following dates I. no effectiveness II. no effectiveness III. no effectiveness III. effective II	F	556		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	1 00/07/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 656	Continued From page	e 83	F 65	6		
	failed to evidence any scale or effectiveness. Review of the "Pain L clinical record failed t from 5/1/19 through 6 The May 2019 MAR 6 for Tramadol. The me	Level Summary" in the o evidence any level of pain 6/6/19. documented the above order edication was documented				
	dates and times: 6/3/19 at 6:00 p.m Review of the nurse's	effective. s notes for the above date of documentation of a pain				
	scale prior to the admadministration of the administration of the An interview was conpractical nurse) #3 or asked the process for of pain, LPN #3 state resident, ask the pain non-pharmacological repositioning or distrawe give the pain med with the resident in 30 where all of that is do 'It's in the nurse's not purpose of the care pplan of care for each should be followed, L	ducted with LPN (licensed of 6^19 at 10:31 a.m. When of when a resident complains down, "First you assess the of scale, and try interventions like of action. If that is not effective dication and then follow up 0-60 minutes." When asked ocumented, LPN #3 stated, es." When asked the olan, LPN #3 stated it's the resident. When asked if it PN #3 stated, "Absolutely."				
	when a resident com	When asked the process for plains of pain, LPN #1 eresident, assess them, ask				

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		COMPLETED				
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	ROVIDER OR SUPPLIER D NURSING AND REH	ABILITATION CENTER	73	TREET ADDRESS, CITY, STATE, ZIP CODE O LUNENBURG HIGHW EYSVILLE, VA 23947	·		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 656	the pain scale, try interventions. If the pain medication arminutes to see if it' where the assessed documented, LPN under the vital sign clinical record and there. And you show When asked the pure of the pure	non-pharmacological at is not effective, I will give the ad follow up with them in 30 is effective." When asked ment and pain scale is #1 stated, "There is a tab as section of the computerized we can enter the pain scale ould write a progress note." surpose of the care plan, LPN are give care of the resident eds and preferences. When the followed, LPN #1 stated, do to be reviewed and revised need." If member (ASM) #1, ASM #2 acility nursing consultant, were above findings on 6/6/19 at the followed in the followed prior to exit. The first provided prior to exit.	F 656				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		495226	B. WING				07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAE	BILITATION CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW EYSVILLE, VA 23947	1 00/	01/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From pag		F	656			
	5/8/12 with the diagn severe major depressymptoms, demential disorder, anxiety dischigh blood pressure, The most recent MDS significant change as (Assessment Referencesident was coded ability to make daily I out of a possible 15 of for Mental Status) excoded as requiring to extensive care for tratoileting and hygiene and bladder. A review of the clinical physician's order dat 0.5 mg (milligrams) be needed) for agitation is not an approved us. On 6/05/19 08:24 AM prepare and administ to Resident #44: Zaditor (2) eye drops Miralax (3) 17 grams Voltaren gel (4), appl Depakote (5) sprinkled 2 tabs Calcium (6) 250mg, vigave 1 tab	with behavior, bipolar order, psychotic disorder, diabetes, and cataracts. S (Minimum Data Set) was a sessment with an ARD noce Date) of 5/16/19. The as being cognitively intact in ife decisions, scoring a 14 on the BIMS (Brief Interview am. The resident was stal care for bathing; ansfers, dressing, eating, and was continent of bowel al record revealed a led 5/20/19 for Risperdal (1) wid (twice daily) prn (as a land bipolar. (Note: Anxiety see for Risperdal). 1. LPN #1 was observed to the true the following medications and the cord in each eye					
	At this time she aske needed her "medicat	d Resident #44 if she ion for anxiety." The					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
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		495226	B. WING				06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER	1	730 LU	FADDRESS, CITY, STATE, ZIP CODE NENBURG HIGHW VILLE, VA 23947	,	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 656	appear anxious or a her wheelchair apperson apparent signs or did not offer any nor interventions at this resident's Risperdal drawer. As she was resident asked her was for how with the resident to medications. She a applied the Voltarer She then assisted the wheelchair and admidrops and then gave pills, including the Rights of the state of	did. The resident did not agitated. The resident was in earing very calm. There were fanxiety or agitation. LPN #1	F	556			
	#1, when asked who stated, "anxiety." When asked (prn) and resident had request anxiousness and has was tired, saying I on When asked if it was stated it was. When order stated it was for show that the Rispe When asked about interventions, she sagitated earlier about and bunched up and						

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G		OATE SURVEY COMPLETED
		495226	B. WING			C 06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHA			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	I	06/07/2019
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 656	signs of anxiety or a the Risperdal withou nonpharmacological she had repositioned (in her room with the gel to her knees) an administering all me issues the resident of tired. When it was r interventions were do or after providing the beforehand and thei effectiveness, she s for the medication a When asked what is if a resident needs a that staff should try wants the medicatio situation might be by pharmacological intermedication only after ineffective. Further review of the reveal any nurses no of the resident's anx non-pharmacological review of the back of Administration Record Resident #44 reveal administered for "residential for anxiousness." On 6/06/19 at 7:11 F #4, she stated that F used for aggressive is not used for anxie	sident was not showing any gitation, and she still offered at offering I interventions, she stated that d her clothes a second time e administration of Voltaren d assisted her to bed (after dications) because one of the expressed was that she was noted that these additional lone only in conjunction with e medication, and not in re-evaluated for tated the resident had asked and it was her right to have it. If the process for determining in PRN medication, she stated to figure out why the resident in, try to fix whatever the confering non erventions, and give the in other attempts are se clinical record failed to one desired a dication or any all interventions attempted. A fif the MAR (Medication or dication or June 2019 for led the Risperdal was	F 6	56		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495226	B. WING _			C 06/07/2019	
	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	need to be combati exhibiting some typ stated she would no showing these sym care plan was not for was given for the was given for the was given for the comrevealed one for "President acts characteristic changes in the brain 2/8/18. The interved 2/8/18 for "Monitor facility protocol" and medication as presonand one dated 3/25 anxiety per facility protocol and changes as indicated 6/5/12 documents with the potential effects due to a land and the protocol and the	It that to give it, there would we or aggressive behaviors or e of psychotic behaviors. She of give it if the resident was not ptoms. She stated that the ollowed because the Risperdal rong reason. Inprehensive care plan roblematic manner in which cterized by ineffective coping: gression or Combativeness in impairments/phys (physical) in." This care plan was dated and document behavior per done dated 5/31/18 for "Give cribed by MD (medical doctor); /19 for "Document episodes of protocol and notify MD of ed." In addition, a care plan mented, "Use of psychotropic intial for or characterized by use of medications, tipsychotic." This care plan pervention dated 6/5/12 for tions per physician's order." ity policy, "Resident Care ment that the care plan must	F 6	· ·			
	Staff Member - the Director of Nursing) Consultant) were no	M, ASM #1 (Administrative Administrator), ASM #2 (the and ASM #4 (Facility Nurse otified of the concerns. No was provided by the end of the					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		495226	B. WING _			06/07/2019	
	ROVIDER OR SUPPLIER D NURSING AND REHA	BILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			, 33.0.723.13	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	(1) Risperdal - is an treat schizophrenia, episodes, and beha Information obtained https://medlineplus.stml (2) Zaditor - is an oprelieve the itching of Information obtained https://medlineplus.stml (3) Miralax - is used Information obtained https://medlineplus.stml (4) Voltaren - is a to from osteoarthritis. Information obtained https://medlineplus.stml (5) Depakote - is us bipolar disorder. Information obtained https://medlineplus.stml (6) Calcium - Calciu foods. The body new strong bones and to functions. Almost al and teeth, where it is hardness. The body muscles to move an messages between	antipsychotic and is used to mania, mixed mood viors. d from gov/druginfo/meds/a694015.h othalmic solution used to f allergic pinkeye. d from gov/druginfo/meds/a604033.h d to treat constipation. d from gov/druginfo/meds/a603032.h pical gel used to treat pain d from gov/druginfo/meds/a611002.ht ed to treat seizures and	F 6	56			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONST		COMPLETED					
		495226	B. WING				C /07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAE	ILITATION CENTER		730	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW /SVILLE, VA 23947	1 00/	0112013
(X4) ID PREFIX TAG			ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	vessels move blood thelp release hormone almost every function Information obtained	hroughout the body and to es and enzymes that affect in the human body.	F	356			
	Resident #10 was ad 2/21/19 with the diag high blood pressure, pulmonary disease (*uropathy (2), benign lower urinary tract sy urine. The most rece Set), a Significant Ch assessment, with an date) of 3/18/19, code 9 out of 15 on the BIM Mental Status) score moderate cognitive ir making. The residen assistance for eating bathing, dressing, toi had an indwelling urinoccasionally incontine. On 6/5/19 at 8:44 AM observed that Resident	plan for the administration of #10. mitted to the facility on noses of but not limited to chronic obstructive I), obstructive and reflux prostatic hyperplasia with mptoms, and retention of ent MDS (Minimum Data ange in Status Medicare ARD (Assessment reference ed the resident as scoring a MS (Brief Interview for indicating the Resident had apairment for daily decision to required extensive total care for hygiene, leting, and transfers; and harry catheter and was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER D NURSING AND REHAI	BILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		•	1 00.01.2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	Continued From pag	e 91	F 6	656			
	' '	red 6/1/19, that documented at 3LPM (3 liters per minute)					
	MAR (medication ad	clinical record revealed a ministration record) that was nich documented in part, "O2					
	comprehensive care documented in part, Ineffective Breathing care plan documente	e clinical record revealed a plan dated 3/12/19, that "Potential for or Actual Patter." The comprehensive ed in part, "Interventions" that en therapy (3L/M) via (NC) as					
	#3. When LPN #3 w #10's oxygen is to be three." When LPN # is care planned for o she stated, "Yes." W Resident #10's oxyg per minute, she state at 3 ½." When LPN #10's oxygen set at the	PM an interview was (Licensed Practical Nurse) ras asked what rate Resident e set at, she stated, "His is 3 was asked if Resident #10 xygen at 3 liters per minute, /hen LPN #3 was asked if en rate is to be at 3 ½ liters ed, "It is not supposed to be #3 was asked if Resident the wrong rate is a problem, following orders and the care					
	Plan," with a revisior documented in part, include the instruction effective and patient	ry's policy "Resident Care n date of 11/13/2017, "Baseline care plans will ns needed to provide -centered care for residents al standard of quality care"					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRAND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495226	B. WING _			C 06/07/2019
	ROVIDER OR SUPPLIER O NURSING AND REHA	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 656	Nursing, 7th Edition care plan communion other health care pure plan enhances the specific nursing into the goals of care. In the goals of care, blueprint for nursing for implementation for evaluation of the actions." On 6/7/19 at 11:48 Member) #1, the Aurof the findings. No provided by the end (1) Chronic obstruction obstruction of the season obtained from the very plan of the season of th	r and Perry's, Fundamentals of n, page 269 states "A written cates nursing care priorities to rofessionals. The nursing care continuity of care by listing erventions needed to achieve The complete care plan is the g action. It provides direction of the plan plus the framework e client's response to nursing AM, ASM (Administrative Staff dministrator, was made aware further information was d of the survey. Stive pulmonary disease: s it difficult to breath that can if breath. This information was	F 6	56		
	uropathy is a condi is blocked. This cal injure one or both k obtained from the v https://medlineplus	gov/ency/article/000507.htm failed to implement the re plan for the administration of				
		admitted to the facility on agnoses of but not limited to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED		
		495226	B. WING			C 06/07/2019	
	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	heart failure, chronic disease (1), obstruct and retention of urin (Minimum Data Set) assessment, with an date) of 5/28/19, cool out of 15 on the B Mental Status) scorrevere cognitive improvements. The reside set up for eating; exhygiene, dressing, to bathing; had an interest of the set up for bathing; had an interest of the set up for eating; exhygiene, dressing, to bathing; had an interest of the set up for bathing in	ge 93 itus, high blood pressure, cobstructive pulmonary tive and reflux uropathy (2), e. The most recent MDS of a 14-day Medicare of ARD (Assessment reference ded the resident as scoring a IMS (Brief Interview for e., indicating the Resident had pairment for daily decision ont required supervision and tensive assistance for colleting, transfers: total care indwelling urinary catheter by incontinent of bowel.	F 6	56			
	On 6/4/19 at 6:00 P was observed that F flowrate on the oxyg ½ liters per minute. A review of the clinic physician's order dain part, "O2 (oxygen NC (nasal cannula) Further review of the MAR (medication acd dated June 2019, wat 2L via NC" Further review of the comprehensive care documented in part, Ineffective Breathing comprehensive care	M and 6/5/19 at 8:36 AM, it Resident #49's oxygen pen concentrator was set at 2 cal record revealed a ted 6/1/19, that documented at 2 calinical record revealed a diministration record) that was hich documented in part, "O2 ce clinical record revealed a plan, dated 5/9/19, that "Potential for or Actual gratter" The eplan documented in part, noted in part, "Oxygen					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B. WING			C
	ROVIDER OR SUPPLIER NURSING AND REHAE			STREET ADDRESS, CITY, STATE, ZIP COI 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	06/07/2019 CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 656	#3. When LPN #3 w #49's oxygen rate is liters." When LPN #3 w #49's oxygen rate is minute, how do you was stated, "You get The ball would be on above it." When LPN #49's oxygen rate se following the care planot." A review of the facilit Plan" with a revision documented in part, include the instruction effective and patient that meet profession. According to Potter and Nursing, 7th Edition, care plan communication of the alth care proplan enhances the complant enhances the complant of the goals of care. The blueprint for nursing for implementation of the actions." On 6/7/19 at 11:48 A Member) #1, the Addrof the findings. No fur provided by the end was served.	M an interview was (Licensed Practical Nurse) as asked what Resident to be set at, she stated, "2 3 was asked if Resident to be set at 2 liters per know where to set the ball, down on eye level to set it. the 2 line, not below or M #3 was asked if Resident to at the wrong rate is an, she stated, "Apparently y's policy "Resident Care date of 11/13/2017 that "Baseline care plans will as needed to provide centered care for residents all standard of quality care" and Perry's, Fundamentals of page 269 states "A written ates nursing care priorities to fessionals. The nursing care continuity of care by listing ventions needed to achieve the complete care plan is the action. It provides direction of the plan plus the framework client's response to nursing M, ASM (Administrative Staff ministrator, was made aware urther information was	F 6	56		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COMPLETED		
		495226	B. WING		C 06/07/2019		
	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	·		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION		
F 656	lead to shortness of obtained from the whttps://www.nlm.nih (2) Obstructive and uropathy is a condit is blocked. This cau injure one or both ki obtained from the whttps://medlineplus. 7. The facility staff for comprehensive care oxygen for Resident #48 was a 12/18/19 with the diadult failure to thrive pathological fracture intertrochanteric framost recent MDS (Nouarterly Medicare (Assessment refere the resident as scor (Brief Interview for Nondicating the Resident was a side of the resident as scor (Brief Interview for Nondicating the Resident was conditionally side of the resident as scor (Brief Interview for Nondicating the Resident was conditionally side of the resident as scor (Brief Interview for Nondicating the Resident was conditionally side of the pathological fracture in the pa	it difficult to breath that can breath. This information was ebsite: .gov/medlineplus/copd.html. reflux uropathy: Obstructive ion in which the flow of urine ses the urine to back up and dneys. This information was ebsite: gov/ency/article/000507.htm ailed to implement the eplan for the administration of #48. dmitted to the facility on agnoses of but not limited to eposte or just the current eposte of right femur. The Minimum Data Set), a assessment, with an ARD ince date) of 5/20/19, coded ing a 3 out of 15 on the BIMS Mental Status) score, ent had severe cognitive	F 65	66			
	resident was independent extensive assistance total care for toileting frequently incontine On 6/5/19 at 8:30 A observed that Resident extensive assistance.	decision making. The endent for eating; required the for hygiene and dressing; grand bathing; and was not of bladder and bowel. Mand 10:24 AM, it was lent #48's oxygen flowrate on the following set at 3 liters per					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL [*] A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495226	B. WING				07/2019
	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER		730	REET ADDRESS, CITY, STATE, ZIP CODE D LUNENBURG HIGHW EYSVILLE, VA 23947	1 00	0172010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	in part, "Oxygen at 2 (nasal cannula)" Further review of the MAR (medication ad dated June 2019, wh "Oxygen at 2 liters (procession of the comprehensive care 12/19/18, that docur or Actual Ineffective comprehensive care "Interventions" that in therapy (3L) via (NCOOn 6/6/19 at 12:43 Fronducted with LPN #3. When LPN #3 when LPN #48's care plan was oxygen order, she standard with a revision documented in part, include the instruction effective and patient that meet profession.	cal record revealed a ted 5/4/19, that documented be liters (per minute) via N/C be clinical record revealed a diministration record) that was nich documented in part, per minute) via N/C (nasal be clinical record revealed a plan that was dated mented in part, "Potential for Breathing Patter" The plan documented in part, noted in part, "Oxygen) as ordered." PM an interview was (Licensed Practical Nurse) vas asked what Resident to be set at, she stated, "His PN #3 was asked if Resident updated to reflect the current tated, "Apparently not." by's policy "Resident Care date of 11/13/2017 that "Baseline care plans will ons needed to provide centered care for residents all standard of quality care"	F	656			
	Nursing, 7th Edition,	and Perry's, Fundamentals of page 269 states "A written ates nursing care priorities to					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	A. BUILDING		OMPLETED
		495226	B. WING			C
	ROVIDER OR SUPPLIER NURSING AND REHAB	I		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	l	06/07/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	other health care proplan enhances the conspecific nursing intervente goals of care. The blueprint for nursing a for implementation of for evaluation of the constant of the c	fessionals. The nursing care ontinuity of care by listing ventions needed to achieve e complete care plan is the action. It provides direction the plan plus the framework client's response to nursing M, ASM (Administrative Staff ninistrator, was made aware orther information was	F 65	56		
	Resident #14 was ad 8/24/18 with the diag dementia without ber psychotic disorder, at blood pressure. The Data Set), a Quarter an ARD (Assessment coded the resident as the BIMS (Brief Internscore, indicating the cognitive impairment The resident was indicated that the supervision and set up was always continent	plan for the use of ion for Resident #14. mitted to the facility on noses of but not limited to navioral disturbance, brief nxiety disorder, and high most recent MDS (Minimum y Medicare assessment, with the reference date) of 4/1/19, as scoring a 12 out of 15 on view for Mental Status) Resident had moderate for daily decision making. ependent for bathing,				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495226	B. WING				07/2019	
	ROVIDER OR SUPPLIER NURSING AND REHAE	BILITATION CENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW (EYSVILLE, VA 23947	1 00/	0772013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 656	Continued From pag	e 98	F	656				
	Resident #14 exhibite dining room.	ed no behaviors while in the						
		M, and 6/6/19 at 9:35 AM, it esident #14 exhibited no er room.						
		M, it was observed that ed no behaviors while in her lway.						
	notes dated 4/9/19, v "Re-evaluated reside	al record revealed nurse's which documented in part, ent for wandering. k, removed wander guard						
	notes dated 5/8/19 a	observed resident resting						
		clinical record revealed no documenting behaviors.						
	in part, "Seroquel	ed 6/1/19, that documented (1) 12.5 mg (milligrams) po ery evening at bed time) for						
	MAR (medication ad							
		clinical record revealed a plan that was dated 8/24/18,						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED
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	ROVIDER OR SUPPLIER NURSING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	<u> </u>	00/01/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	that documented in p drugs with the potent side effects ofAEB to diagnosis of: psych anti-psychotic (GDR: Dose Reduction)." T documented in part, ' part, "Observe interar for appropriateness status functioning on A review of the clinica physician's note date documented in part, ' systemspsychiatric or suicidal ideations Mood and affect plea person and placePl care reviewed by pro plan of care Further review of the physician's note date documented in part, ' systemspsychiatric no changes in cogniti examPsychiatric: N patient oriented to pe medications and plan provider" Further review of the physician's note date documented in part, ' systemspsychiatric ro suicidal ideations Mood and affect plea	art, "Use of psychotropic ial for or characterized by (As Evidenced By): or / due nosis, Insomnia, use of Seroquel 5/6/19) (Gradual he comprehensive care plan Interventions" that noted in ction or resident with others observe resident's mental an ongoing basis al record revealed a dot 12/15/18, which service wof it No increased nervousness on the patient oriented to an imedications and plan of vidercontinue with present services of it No increased nervousness on medications and plan of vidercontinue with present services of it No increased nervousness on hybrical lood and affect pleasant; rson and placePlan: of care reviewed by clinical record revealed a dot 3/23/19, which services of it No increased nervousness on hybrical examPsychiatric is no increased nervousness of the increased nervousness of t	F 65	6		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONST	TRUCTION		PLETED
		495226	B. WING				C /07/2019
	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER	•	730 LUN	ADDRESS, CITY, STATE, ZIP CODE IENBURG HIGHW ILLE, VA 23947	1 00/	0172010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	physician's note dat in part, "Review or changes in cognition nervousnessPhysiand affect pleasant; and placePlan: m reviewed by provide Further review of the physician's note dat documented in part, dementia. She required for meals and assist daily living. She enjactivitiesReview or changes in cognition examPsychiatric: patient oriented to p medications and pla provider"	e clinical record revealed a ed 4/3/19, which documented of systemspsychiatric: No nor increased ical examPsychiatric: Mood patient oriented to person edications and allergies edications and allergies ed" e clinical record revealed a ed 4/19/19, which "(name of resident) has uires direction from the stafficance with her activities of oys playing bingo and group of systemspsychiatric: No nor crying spellsPhysical Mood and affect pleasant; erson and placePlan: no for care reviewed by	F	556			
	assessment, with an documented in part, above; 200: Behavior not exhibited; 900: E A review of the clinic dated 1/4/19, a Quaresessment, with an documented in part, above; 200: Behavior not exhibited; 900: E A review of the clinic	uarterly - modified Medicare n ARD of 8/24/18, which "Section E: 100: None of the or not exhibited; 800: Behavior Behavior not exhibited." cal record revealed MDS rterly - modified Medicare n ARD of 1/4/19, which "Section E: 100: None of the or not exhibited; 800: Behavior Behavior not exhibited." cal record revealed MDS rterly Medicare assessment,					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		495226	B. WING _			C 06/07/2019	,
	ROVIDER OR SUPPLIER D NURSING AND REHAE	BILITATION CENTER	1	STREET ADDRESS, CITY, STATE, ZIP 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	CODE	00/01/2010	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		TION SHOULD BE THE APPROPRIA		TION
F 656	Continued From pag with an ARD of 3/8/1 "Section E: 100: Non Behavior not exhibite exhibited; 900: Beha A review of the clinic dated 4/1/19, a Quar with an ARD of 4/1/1 "Section E: 100: Non Behavior not exhibite exhibited; 900: Beha On 6/6/19 at 12:43 P conducted with LPN #3. When LPN #3 w receives Seroquel, s but I think she does.' Resident #14 exhibit the need for Seroque when she was move term care. She had s #3 was asked when she stated, "It was in was asked if Resider behaviors since, she and I guess that is w	e 101 9, which documented in part, e of the above; 200: ed; 800: Behavior not vior not exhibited." al record revealed MDS terly Medicare assessment, 9, which documented in part, e of the above; 200: ed; 800: Behavior not vior not exhibited." M an interview was (Licensed Practical Nurse) as asked if Resident #14 he stated, "Not on my shift," When LPN #3 was asked if any behaviors indicating el, she stated, "She was d from back here to long some behaviors." When LPN Resident #14 was moved, Nov 2018." When LPN #3					
	When LPN #3 was a would document Res stated, "You would p under behavior." When should Resident #14 she stated, "Yes." Where is a problem when the stated, "Yes." When stated, "Yes." When stated, "Yes." When stated, "Yes."	anned, she stated, "Yes." sked where the nurses sident #14's behaviors, she ut them in the progress notes hen LPN #3 was asked s behaviors be documented, shen LPN #3 was asked if hen behaviors are not hen no behaviors are noted, shen LPN #3 was asked if it haviors are documented, she bewing the care plan."					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER NURSING AND REHAI	BILITATION CENTER		730	REET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW YSVILLE, VA 23947	1 00/	0112013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 656	Continued From pag	e 102	F	656				
	Plan" with a revision documented in part, include the instruction effective and patient that meet profession. According to Potter a Nursing, 7th Edition, care plan communic other health care proplan enhances the cospecific nursing interesting the goals of care. The blueprint for nursing for implementation of the part of the professional pro	date of 11/13/2017 that "Baseline care plans will ns needed to provide -centered care for residents al standard of quality care" and Perry's, Fundamentals of page 269 states "A written ates nursing care priorities to offessionals. The nursing care ontinuity of care by listing ventions needed to achieve ne complete care plan is the action. It provides direction of the plan plus the framework client's response to nursing						
	Member) #1, the Adı of the findings. No fi provided by the end (1) "Seroquel (Quetia extended-release (lot treat the symptoms of illness that causes doss of interest in life emotions). Quetiapir extended-release tal with other medication (frenzied, abnormally depression in patien (manic depressive docauses episodes of mania, and other about the end of the first provided in the first provided i	apine) tablets and ng-acting) tablets are used to of schizophrenia (a mental isturbed or unusual thinking, , and strong or inappropriate						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495226	B. WING _			07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	bipolar disorder. Que tablets are also used medications to treat of tablets may be used a program to treat bipol schizophrenia in child Quetiapine is in a clas atypical antipsychotic activity of certain natu This information was	nedications to prevent depression in patients with tiapine extended-release along with other depression. Quetiapine as part of a treatment lar disorder and	F 6			7/21/19
SS=E	S 483.25 Quality of car Quality of care is a further applies to all treatment facility residents. Base assessment of a resident residents received accordance with professor practice, the compreheractice, the compreheractice, the compreheractice plan, and the rest This REQUIREMENT by: Based on staff intervant clinical record restraction of the survey sample, and #48. The facility medications to Reside orders and failed to expense the survey sample, and #48. The facility seeds and failed to expense the survey sample, and #48. The facility seeds and failed to expense the survey sample, and #48. The facility seeds and failed to expense the survey sample, and #48. The facility seeds and failed to expense the survey sample, and #48. The facility seeds and failed to expense the survey sample, and #48.	ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in essional standards of nensive person-centered		F-684 The nurse responsible for Resident #3 was in-serviced regarding the physicial order pertaining to blood pressure medication. Hospice orders were obtained for resident #s 13, 10, and 4 Upon further observation no other resident was found not to have proper orders. The physician orders will be reviewed	an 8.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495226	B. WING _			06	C 6/07/2019	
	ROVIDER OR SUPPLIER NURSING AND REHAI	BILITATION CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 80 LUNENBURG HIGHW EYSVILLE, VA 23947	1 00	10112013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 684	#10 and #49. The findings include 1. The facility staff farmedication according Resident #33. Resident #33 was ac 5/1/19 with diagnose limited to: dementia, diabetes, stroke and pulmonary disease nonreversible lung discombination of empth bronchitis) (1). The most recent MD assessment, an admassessment reference resident as scoring a interview for mental is severely impaired decisions. The resident extensive assistance one staff member for living. The physician order "Metoprolol Tartrate"	dmitted to the facility on es that included but were not high blood pressure, COPD (chronic obstructive general term for chronic, isease that is usually a hysema and chronic S (minimum data set) hission assessment, with an ce date of 5/8/19, coded the a "3" on the BIMS (brief status) score, indication she to make daily cognitive ent was coded as requiring e to being dependent upon r all of her activities of daily	F	684	each month to ensure that Hospice ordare in place. Nursing staff will be in-serviced as to the importance of detailed compliance with Physician ordespecially when dictated parameters a involved. The Director of Nursing or her designed will review the monthly orders to ensure that the Orders are complete and proper documented. The monthly compliance review will be submitted to the Cardina IDT members for any follow \(\precedup \text{up}. \) Reviews will then be submitted to the facility \(\precedup \text{ QAPI members for oversight} \)	ders ire ee ee erly e		
	by mouth twice daily pressure) less than than 50."	(milligrams) 1/2 = 12.5 mg . Hold for SBP (systolic blood 100 or HR (heart rate) less 019 MAR (medication d) documented the above						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDII	JLTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER NURSING AND REHAE	BILITATION CENTER		STREET ADDRESS, CITY 730 LUNENBURG HIGH KEYSVILLE, VA 2394	iw	, 50			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 684	9:00 a.m., 5/23/19 at 9:00 p.m. The reverse evidence documental medication was not good Review of the nurse' dates and times faile as to why the medication was not good to the comprehensive documented in part, blood pressure): at rifailure, arteriosclerot retinopathy." The "In part, "Monitor blood and/or as ordered by An interview was corpractical nurse) #2 o was asked to read the When asked what sthem that order, LPN; the blood pressure a When asked what the were, LPN #2 stated wasn't signed off." When a stated wasn't signed off. "When a stated wasn't signed off." When a stated wasn't signed off." When a stated wasn't signed off. "When a stated wasn't signed off." When a stated wasn't signed off. "When a stated wasn't signed off." When a stated wasn't signed off. "When a stated wasn't signed off." When a stated wasn't signed off. "When a stated wasn't signed off." When a stated wasn't signed off. "When a stated wasn't signed off." When a stated wasn't signed off. "When a stated wasn't signed off." When a stated wasn't signed off. "When a stated wasn't signed off." When a state	not signed off on 5/22/19 at 19:00 p.m. and 5/26/19 at 19:00 p.m. as to why the 19:00 p.m. as notes for the above listed 19:00 p.m. as notes for the above listed 19:00 p.m. at 19:0	F	584					
		"N. Any deviation from the							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG	, ,	OATE SURVEY OMPLETED	
		495226	B. WING _			C 06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	'	00/07/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COME (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From pag		F 6	84		
	medication error: 1. Administration of the right dose. 4. By the method. 6. At the rig document any menti prescribed vital sign medication.	shall be considered a To the right resident. 2. e right medication. 3. In the right route. 5. By the right that time." The policy failed to ion of obtaining the s prior to administration of a strator and ASM #4, the				
		ant, were made aware of the				
	Non-Medical Reade Chapman, page 124 (2) This information following website:	ary of Medical Terms for the r, 5th edition, Rothenberg and l. was obtained from the gov/druginfo/meds/a682864.h				
		ailed to ensure a current or the provision of Hospice #13				
	diagnoses of atrial fi depression, chronic disease, anxiety disc hemiplegia, respirate bladder. The most r Set) was a significar ARD (Assessment F The resident was co in ability to make da resident was coded bathing, toileting and assistance for dress	dmitted on 2/6/15 with the brillation, hypothyroidism, obstructive pulmonary order, intestinal obstruction, ory failure, and neurogenic recent MDS (Minimum Data at change assessment with an Reference Date) of 3/22/19. ded as moderately impaired dily life decisions. The as requiring total care for d transfers; extensive ing; supervision for eating; of bowel and had an				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495226	B. WING				07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	1 00/	0772019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page indwelling catheter fo		F	684			
	A review of the clinica dated 3/18/19 for "Ad	al record revealed an order mit to Hospice (name of ' This order was signed by					
	current orders, for Ma physician on 5/4/19), by the physician on 6	cian's order sheet (POS) of ay 2019 (signed by the and for June 2019, signed /1/19, failed to reveal any for the provision of Hospice					
	most recent note refe 5/30/19 at 12:41 PM: meeting invitation ma representative), and I company)" indication	clinical record revealed the rring to Hospice, dated "Scheduled care plan iled to RR (resident Hospice (name of hospice ing that the resident was still rvices, without a current					
	Assessment and Plar dated 5/16/19, indica receiving Hospice aft	a "Hospice Comprehensive n of Care Update Report" ting that the resident was still er the May 2019, POS was out a current Hospice order					
	#3, she stated that th Hospice. LPN #3 sta May 2019 and June 2 was getting Hospice because the physicia indicating that those	M, in an interview with LPN e resident was still on ted that, after reviewing the 2019 POS, that the resident without a current order in had signed the POS orders were all the current s, and that Hospice was not					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		_	(X3) DATE SURVEY COMPLETED	
		495226	B. WING _		_	06/0) 7/2019
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, S' 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		1 00/0	7772013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	did not document that was required for the properties. On 6/6/19 at 7:43 PM Staff Member - the Additional Director of Nursing) at Consultant) were notified.	policy, "Hospice Residents" t a current physician's order	F	584			
	were in place for the services to Resident and 2/21/19 with the diagrating blood pressure, pulmonary disease (1 uropathy (2), benign plower urinary tract syrurine. The most recesset), a Significant Chassessment, with an date) of 3/18/19, code 9 out of 15 on the BIM Mental Status) score, moderate cognitive in making. The resident assistance for eating: bathing, dressing, toil	mitted to the facility on noses of but not limited to chronic obstructive), obstructive and reflux prostatic hyperplasia with mptoms, and retention of nt MDS (Minimum Data ange in Status Medicare ARD (Assessment reference ed the resident as scoring a MS (Brief Interview for indicating the Resident had apairment for daily decision					

· /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B. WING				07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAE	ILITATION CENTER		730	EET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW //SVILLE, VA 23947	1 00/	01/2019
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	A review of the clinical physician's order for of April 2019, May 2019. A review of the clinical comprehensive care documented in part, of the conducted in part, of the conducted with LPN with an effective date. A review of the facility with an effective date.	al record failed to reveal a Hospice care for the months 19, and June 2019. al record revealed a plan dated 3/12/19, which "Hospice Care due to to thrive" I, an interview was (Licensed Practical Nurse)	F	684			
	nursing facility will co agree upon a coordin providers" Although LPN #3 pro for hospice care, date evidence to indicate the entered or carried ov system for the month and June 2019. On 6/7/19 at 11:48 A	hospice agency and the mmunicate, establish, and lated plan of care for both vided the handwritten order led March 2019, there was no shat this order was ever ler into the physician order is of April 2019, May 2019, M, ASM (Administrative Staff ninistrator, was made aware					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495226	B. WING		C 06/07/2019	
	ROVIDER OR SUPPLIER NURSING AND REHAE			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	1 00/07/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 684	the survey. (1) An indwelling caurine from the bladded body. This information website: https://medlineplus.go.00140.htm (2) Chronic obstruct Disease that makes is lead to shortness of the obtained from the wehttps://www.nlm.nih.go. (3) Obstructive and uropathy is a condition is blocked. This causinjure one or both kidd obtained from the wehttps://medlineplus.go.4. The facility staff fail	theter is a tube that drains er to a bag outside of the on was obtained from the ov/ency/patientinstructions/0 ive pulmonary disease: t difficult to breath that can breath. This information was ebsite: gov/medlineplus/copd.html. reflux uropathy: Obstructive on in which the flow of urine es the urine to back up and ineys. This information was	F 68	34		
	12/18/19 with the dia adult failure to thrive, pathological fracture, intertrochanteric fract most recent MDS (Mi Quarterly Medicare a (Assessment referen	ture of right femur. The				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG	` '	(X3) DATE SURVEY COMPLETED	
		495226	B. WING _			C 06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	•	00/07/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From pag	ge 111 Mental Status) score,	F 6	84		
	indicating the Resid impairment for daily resident was indepe extensive assistance total care for toiletin	ent had severe cognitive decision making. The ndent for eating; required for hygiene and dressing; g and bathing; and was nt of bladder and bowel.				
	dated 5/20/19, secti	cal record revealed a MDS on O, documented in part, " ne box for "while a resident"				
		cal record failed to reveal a Hospice care for the month				
	comprehensive care	cal record revealed a e plan dated 12/19/18, which "Hospice Care due to				
	(Licensed Practical LPN #3 was asked i Hospice Care. LPN asked if Resident #	M, an interview with LPN Nurse) #3 was conducted. f Resident #10 is currently on #3 stated, "Yes." When 0 has a current order for ated, "I don't see one."				
		M, LPN #3 returned, and order for Hospice Care."				
	with an effective dat part, "When a reside hospice benefits, the nursing facility will c	ty policy "Hospice Residents," e of 1/2009, documented in ent has also elected the e hospice agency and the ommunicate, establish, and nated plan of care for both				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUC AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING				(X3) DATE SURVEY COMPLETED		
		495226	B. WING _			C 06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BI	DATE
F 684	Continued From page		F 6	384		
F 695 SS=E	Respiratory/Tracheos CFR(s): 483.25(i)	stomy Care and Suctioning	F 6	195		7/21/19
	The facility must ensineeds respiratory car care and tracheal succare, consistent with practice, the comprehence plan, the resider and 483.65 of this sure This REQUIREMENT by: Based on observation record review, and fawas determined the frespiratory care and sprofessional standard comprehensive person of 33 sampled reside #48, #46 and Reside failed to administer of physician's orders to and #46, and failed to nebulizer mask was sufficiently staff failed: 1. The facility staff failed to care and the facility staff failed:	nd tracheal suctioning. ure that a resident who e, including tracheostomy etioning, is provided such professional standards of nensive person-centered nts' goals and preferences, bpart. is not met as evidenced n, staff interview, clinical cility document review, it acility staff failed to provide services consistent with		F-695 The oxygen level was adjuproper flow for Residents: and 46. The oxygen Nebu#33 was properly cleaned Other residents requiring tobserved and necessary awere done. No other nebulocated. Nursing staff will be in-ser proper settings of Oxygen way to observe the rate of physician orders. Each shadocument through observations are at settings, there will be a log nurses station that will in observations and settings, be checked daily for propersidents.	#10., 49, 48, dizer for resid and stored. Oxygen were adjustments ulizers were viced on the and the proper flow per hift will ation that the proper g kept at each dicate.	per h will

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B. WING _			l	C /07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAE	BILITATION CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 80 LUNENBURG HIGHW EYSVILLE, VA 23947	1 00	0112019
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 695	Resident #10 was ad 2/21/19 with the diag high blood pressure, pulmonary disease (auropathy (2), benign lower urinary tract sy urine. The most recest, a Significant Chassessment, with an date) of 3/18/19, cod 9 out of 15 on the BII Mental Status) score moderate cognitive ir making. The resident assistance for eating bathing, dressing, to indwelling urinary cat incontinent of bowel. On 6/5/19 at 8:44 AM #10's oxygen flowrate was observed set at minute. A review of the clinical physician's order data in part, "O2 (oxygen) via NC (nasal cannul Further review of the MAR (medication and dated June 2019, what 3LPM via NC" Further review of the comprehensive care documented in part, Ineffective Breathing	Imitted to the facility on noses of but not limited to chronic obstructive 1), obstructive and reflux prostatic hyperplasia with mptoms, and retention of ent MDS (Minimum Data range in Status Medicare ARD (Assessment reference ed the resident as scoring a MS (Brief Interview for indicating the Resident had mpairment for daily decision at required extensive total care for hygiene, leting, and transfers; had an inheter and was occasionally 1, and at 2:32 PM, Resident e on the oxygen concentrator three and a half liters per al record revealed a ed 6/1/19, that documented at 3LPM (3 liters per minute)	F	695	and storage. The bag in which the nebulizer is kept will be dated to indicathe latest date checked and cleaned. Oxygen settings log will be reviewed weekly by the Cardinal IDT members tensure compliance.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	1 00	10112013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 695	ordered." On 6/6/19 at 12:43 I conducted with LPN #3. LPN #3 was ask #10's oxygen was o is three." When ask planned for oxygen stated, "Yes." Wher oxygen rate is to be #3 stated, "It is not sasked what it means the rate ordered by "It is not following or A review of the facili with a revision date part, " Adjust the fundamedition, Potter and Fundamedition, Potter and Fundamedication, Potter and Fundamedication administration."	en therapy (3L/M) via (NC) as PM, an interview was (Licensed Practical Nurse) eed what flow rate Resident rdered at, LPN #3 stated, "His ed if Resident #10 was care at 3 liters per minute, LPN #3 in was asked if Resident #10's at 3 ½ liters per minute, LPN supposed to be at 3 ½." When efficient if the oxygen was not set at the physician, LPN #3 stated, rders and the care plan." ty's policy "Oxygen Therapy," of April 2017, documented in flow meter to prescribed rate mentals of Nursing, 6th Perry, 2005, page 1122, treated as a drug. It has cts, such as atelectasis or mson, 2002). As with any concentration of oxygen asly monitored. The nurse ck the physician's orders to its receiving the prescribed on. The six rights of ration also pertain to oxygen AM, ASM (Administrative Staff ministrator, was made aware further information was	F 6	95			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
		495226	B. WING		C 06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAB	11 1		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 695	Disease that makes i lead to shortness of to obtained from the we https://www.nlm.nih.g. (2) Obstructive and reuropathy is a condition is blocked. This causinjure one or both kidd obtained from the we https://medlineplus.get. 2. The facility staff fait #49's oxygen according the staff fait #49's oxygen according to the staff fait #49's oxygen according #49's oxygen according to the staff fait #49's oxygen according #49's oxygen accordi	re pulmonary disease: t difficult to breath that can breath. This information was bsite: gov/medlineplus/copd.html. eflux uropathy: Obstructive on in which the flow of urine es the urine to back up and neys. This information was bsite: bv/ency/article/000507.htm led to administer Resident ng to the physician's orders. mitted to the facility on noses of but not limited to rus, high blood pressure, obstructive pulmonary ve and reflux uropathy (2), e. The most recent MDS a 14-day Medicare ARD (Assessment reference ed the resident as scoring a MS (Brief Interview for indicating the Resident had airment for daily decision t required supervision and ensive assistance for fleting, transfers: total care elling urinary catheter and	F 69	95	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l \			(X3) DATE SURVEY COMPLETED		
		495226	B. WING			l	C 07/2019	
	ROVIDER OR SUPPLIER NURSING AND REHAE	BILITATION CENTER		730	REET ADDRESS, CITY, STATE, ZIP CODE CUNENBURG HIGHW SYSVILLE, VA 23947	1 00	0172010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 695	Continued From pag	e 116	F	695				
	in part, "O2 (oxygen) NC (nasal cannula). Further review of the MAR (medication addated June 2019, what 2L via NC" Further review of the comprehensive care documented in part, Ineffective Breathing comprehensive care "Interventions" that in therapy (2L/M) via (NOn 6/6/19 at 12:43 P conducted with LPN #3. When asked who flow rate was per the stated, "2 liters." Who set the oxygen flow roncentrator, LPN #3 eye level to set it. The on the 2 line, not below the stated in	ed 6/1/19, that documented at 2L (2 liters per minute) via" clinical record revealed a ministration record) that was ich documented in part, "O2 clinical record revealed a plan, dated 5/9/19, that "Potential for or Actual Patter" The plan documented in part, oted in part, "Oxygen IC) as ordered." M, an interview was (Licensed Practical Nurse) at Resident #49's oxygen physician order, LPN #3 ien asked how staff should						
	A review of the facilit with a revision date of	cian, LPN #3 stated, "It is not the care plan." y's policy "Oxygen Therapy" of April 2017, documented in the pow meter to prescribed rate						
		nentals of Nursing, 6th						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER NURSING AND REHA	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	•	00/07/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 695	"Oxygen should be dangerous side efferoxygen toxicity (The drug, the dosage of should be continuous should routinely cheverify that the clientoxygen concentration administration." On 6/7/19 at 11:48 Member) #1, the Adof the findings. No provided by the ending that the clientoxygen concentration administration." On 6/7/19 at 11:48 Member) #1, the Adof the findings. No provided by the ending that the findings of the findings o	Perry, 2005, page 1122, treated as a drug. It has ects, such as atelectasis or omson, 2002). As with any reconcentration of oxygen usly monitored. The nurse eck the physician's orders to it is receiving the prescribed on. The six rights of tration also pertain to oxygen was a doften the survey. AM, ASM (Administrative Staff dministrator, was made aware further information was doft the survey. Itive pulmonary disease: It is it difficult to breath that can fibreath. This information was vebsite: In gov/medlineplus/copd.html. It reflux uropathy: Obstructive tion in which the flow of urine uses the urine to back up and idneys. This information was	F 6	95			
	#48's oxygen accor Resident #48 was a 12/18/19 with the d	admitted to the facility on iagnoses of but not limited to the facility on e, osteoporosis with current					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION G	COMPLE	(X3) DATE SURVEY COMPLETED		
		495226	B. WING		06/07	/2019	
	ROVIDER OR SUPPLIER D NURSING AND REHAL	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	, 55.51.	.2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 695	intertrochanteric fract most recent MDS (M Quarterly Medicare at (Assessment referent the resident as scori (Brief Interview for M indicating the Reside impairment for daily resident was independent was independent of the compart of the compart of the compart of the comprehensive assistance of the comprehensive at the comprehensive care large for toileting frequently incontiner. On 6/5/19 at 8:30 AM #48's oxygen flowrat was observed set at the compart of the comprehensive care large for the compart of th	eture of right femur. The linimum Data Set), a clinimum Data Set), a clinical record revealed a	F 69	95			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ` ′	IPLE CONSTRUCTION IG	' '	(X3) DATE SURVEY COMPLETED	
		495226	B. WING _			C 06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	•	33/37/2310
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 695	#3. When asked what rate was per the physistated, "2 liters." Whise the oxygen flow reconcentrator, LPN #3 eye level to set it. The on the 2 line, not below what it meant if the ordered by the physic following orders and a review of the facility with a revision date of documented in part, "prescribed rate" According to Fundamedition, Potter and Peroxygen should be transperous side effect oxygen toxicity (Thordrug, the dosage or oshould be continuous should routinely check verify that the client is oxygen concentration medication administration." On 6/7/19 at 11:48 A Member) #1, the Admof the findings. No furnished by the end of the findings. No furnished by the end of the findings and the same and the findings. The facility staff fair mask in a sanitary marked the same and the same	at Resident #48's oxygen sician's orders, LPN #3 en asked how staff should ate on the oxygen stated, "You get down on the center of the ball would be ow or above it." When asked oxygen was not set at the rate bian, LPN #3 stated, "It is not the care plan." If April 2017, that "Adjust the flow meter to Inentals of Nursing, 6th erry, 2005, page 1122, eated as a drug. It has ts, such as atelectasis or inson, 2002). As with any concentration of oxygen sily monitored. The nurse of the physician's orders to be receiving the prescribed in. The six rights of ation also pertain to oxygen M, ASM (Administrative Staff ininistrator, was made aware urther information was	F 6	95		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495226	B. WING _			C 06/07/2019
	ROVIDER OR SUPPLIER D NURSING AND REHAI	BILITATION CENTER		STREET ADDRESS, CITY, STATE, 2 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	I	00/01/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIAT HENCY)	
F 695	diabetes, stroke and pulmonary disease - nonreversible lung d combination of emph bronchitis) (1). The most recent MD assessment, an admassessment reference resident as scoring a interview for mental is severely impaired decisions. The reside extensive assistance one staff member for living. Observation was maderated one of 4/19 at 2:28 p.m. room. There was a mightstand uncovered the resident's clothin. An interview was compractical nurse) #2 of had just provided the treatment. When ask should be stored who "It's supposed to be (respiratory equipments containers when not the facility policy, "Of documented in part, the mask or cannula placed in a plastic be contamination. The containers when the containers when in the contamination. The containers when in the containers when it is supposed to be contamination. The containers when not the mask or cannula placed in a plastic be contamination. The containers when it is supposed to be containers when not the mask or cannula placed in a plastic be contained in a plasti	high blood pressure, COPD (chronic obstructive general term for chronic, isease that is usually a hysema and chronic S (minimum data set) hission assessment, with an he date of 5/8/19, coded the higher of the BIMS (brief histatus) score, indication she higher of the activities of daily de of Resident #33's room higher of the activities of daily de of Resident was not in the higher of the activities of daily de of Resident was not in the higher of the activities of daily de of Resident was not in the higher of the activities of daily de of Resident was not in the higher of the activities of daily de of Resident was not in the higher of the activities of daily de of Resident was not in the higher of the activities of daily de of Resident was not in the higher of the activities of daily de of Resident was not in the higher of the activities of daily de of Resident was not in the higher of the activities of daily de of Resident was not in the higher of the activities of daily de of Resident was not in the higher of the activities of daily de of Resident was not in the higher of the activities of daily de of Resident was not in the higher of the activities of daily de of Resident was not in the higher of the activities of daily de of Resident was not in the higher of the activities of daily de of Resident was not in the higher of the activities of daily de of Resident was not in the higher of the activities of daily de of Resident was not in the higher of the activities of daily de of Resident was not in the higher of the activities of daily de of Resident was not in the higher of the activities of daily de of Resident was not in the higher of the activities of daily de of Resident was not in the higher of the activities of daily de of Resident was not in the higher of the activities of daily de of Resident was not in the higher of the activities of daily de of Resident was not in the higher of the activities of daily de of Resident was not in the higher of the activities of daily de of	F 6	595		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		495226	B. WING		C 06/07/2019	
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE COMPLETION	١
F 697 SS=D	facility nurse consultate above findings on 6/6 No further information (1) Barron's Dictionate Non-Medical Reader, Chapman, page 124. Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management grovided to residents consistent with profess the comprehensive pand the residents' goand the residents' goand the residents' goand clinical record refacility staff failed to repain management profession in the survest facility staff failed to residents in the survest facility staff failed to residents in the survest facility staff failed to residents in the survest facility staff failed pain scale rating when pain medication to Redocument the effective The findings include: Resident #44 was ad 5/8/12 with a recent reconstruction.	trator and ASM #4, the ant, were made aware of the 1/19 at 7:45 a.m. In was obtained prior to exit. Try of Medical Terms for the 5th edition, Rothenberg and agement. The trator and ASM #4, the ant, were made aware of the 5/19 at 7:45 a.m. The was obtained prior to exit. Try of Medical Terms for the 5th edition, Rothenberg and agement agement is who require such services, assional standards of practice, erson-centered care plan, als and preferences. The is not met as evidenced are with the second the maintain a comprehensive	F 69		ntation in logical e nts ewed the	
	_	dementia, bipolar disorder		the DON or her Designee to ensure	-	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
		495226	B. WING_			C
		495226	B. WING_			6/07/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
WAYLAND	NURSING AND REH	ABILITATION CENTER		730 LUNENBURG HIGHW		
				KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 697	Continued From pa	nge 122	F 6	697		
	[a mental disorder mania and depress blood pressure and by degenerative ch	characterized by episodes of sion (1)], anxiety disorder, high I osteoarthritis [characterized anges in the joints, pain, ng can develop after exercise		proper documentation is The results of these rev documented on the pair Cardinal IDT meeting ro monthly to the facility □s	iews will be n log in the nom and submitted	
	assessment, a sign with an assessment coded the resident (brief interview for the resident was categoritive decisions requiring extensive member for most of Section J - Health Coded under J0800 as having any nonof pain or facial grii	DS (minimum data set) inficant change assessment, it reference date of 5/16/19, as scoring a "14" on the BIMS mental status) score, indicating apable of making daily . The resident was coded as assistance of one staff if her activities of daily living. In Conditions, the resident was as not having been observed verbal signs, vocal complaints macing indicating pain. The if as not having documentation				
	"Ultram (Tramadol) moderately severe by mouth three time." The May 2019 MAI record) documente Tramadol. The med having been admin and times: 5/16/19 at 6:00 a.m documented. 5/16/19 at 10:00 p. documented	r dated, 5/15/19, documented, [used to treat moderate to pain (3)] 50 mg (milligrams), 1 es a day as needed for pain." R (medication administration d the above order for dication was documented as istered on the following dates m no effectiveness m no effectiveness m no effectiveness				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	· /	OATE SURVEY OMPLETED
		495226	B. WING			C 06/07/2040
	ROVIDER OR SUPPLIER NURSING AND REHAL			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	<u> </u>	06/07/2019
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 697	5/21/19 at 2:15 a.m. 5/27/19 at 4:45 p.m. 5/28/19 at 4:45 p.m. 5/28/19 at 4:30 p.m. 5/30/19 at 4:30 p.m. None of the above d pain scale rating pricafter the administration of the administration of the "Pain clinical record failed from 5/1/19 through The June 2019 MAF order for Tramadol. documented as administration of the administration of the "Pain clinical record failed from 5/1/19 through The June 2019 MAF order for Tramadol. documented as administration of the administration of the "Pain Assessmed documented the residence are scale prior to the administration of the "Pain Assessmed documented as having pain scale of 0-10 - 10 ever. It was documented the residence in the right hip. The residence in the residence in the right hip. The residence in the residence in the right hip. The residence in the right hip. The residence in the residence in the right hip. The residence in the residence in the right hip. The residence in the residence in the right hip. The residence in the residence in the right hip.	- medication was helpful - effective - sleeping - effective - effective - effective - effective - occumentation evidenced any or to the administration or ion of the medication. Is notes for the above dates by documentation of a pain is of the medication. Level Summary" in the to evidence any level of pain 6/6/19. It documented the above The medication was sinistered on the following /19 at 6:00 p.m effective. Is notes for the above date by documentation of a pain ministration or after the interpretation or after th	F 6	97		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495226	B. WING		06	C 5/ 07/2019	
	ROVIDER OR SUPPLIER NURSING AND REHAE	I		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 697	documented the reside expression of pain. To documented as having the comprehensive of revised on 5/20/19, do Risk for Potential Pai impaired mobility, has bilateral knees, femule (stroke)." The "Intervented moders and note the conceded of meds (medipain as per MD order Monitor and documented location, severity and factors, etc." An interview was compractical nurse) #3 on asked about the procomplaints of pain, Lassess the resident, non-pharmacological repositioning or distrative give the pain medical with the resident in 3 where all of that infor #3 stated, 'It's in the stated, assess them, ask the non-pharmacological effective, I will give the point modern ask the non-pharmacological effective, I will give the point modern ask the non-pharmacological effective, I will give the point modern ask the non-pharmacological effective, I will give the point manufacture in 30 millions ask them in 30 millions ask	dent could verbalize he resident was ag a pain level of "0." care plan dated, 1/16/17 and ocumented in part, "Focus: n, chronic related to (history of) osteoarthritis, r, right arm pain and CVA entions" documented in part, lication as per MD (doctor) effectiveness. Give PRN (as cations) for breakthrough is and not the effectiveness. In characteristics of pain: frequency, precipitating ducted with LPN (licensed in 6/6/19 at 10:31 a.m. When ess staff follows for resident PN #3 stated, "First you ask the pain scale, and try interventions like action. If that is not effective lication and then follow up 0-60 minutes." When asked mation is documented, LPN nurse's notes." ducted with LPN #1 on When asked about the for resident complaints of "I evaluate the resident,	F 69	7			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		PLE CONSTRUCTION G		TE SURVEY MPLETED		
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	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		0/01/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 697	Continued From page	e 125	F 6	97		
	tab under the vital sig computerized clinical	LPN #1 stated, "There is a ns section of the record and we can enter the you should write a progress				
	Procedure" failed to e	ain Management Policy and evidence anything related to as needed medication and the pain scale.				
	and ASM #4, the facil	nember (ASM) #1, ASM #2 lity nursing consultant, were pove findings on 6/6/19 at				
	No further information	n was provided prior to exit.				
F 756	Non-Medical Reader, Chapman, page 33. (2) Barron's Dictionar Non-Medical Reader, Chapman, page 422. (3) This information w following website: https://medlineplus.go ml Drug Regimen Review	vas obtained from the ov/druginfo/meds/a695011.ht w, Report Irregular, Act On	F 7	56		7/21/19
SS=E	§483.45(c) Drug Reg §483.45(c)(1) The dru must be reviewed at I licensed pharmacist.	imen Review. ug regimen of each resident least once a month by a view must include a review				

	OF DEFICIENCIES CORRECTION			(X3) DATE SURVEY COMPLETED	
		495226	B. WING		C 06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	1 00/07/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 756	Continued From page	e 126	F 750	3	
	irregularities to the at facility's medical direct and these reports mut (i) Irregularities including that meets the co (d) of this section for (ii) Any irregularities induring this review museparate, written report attending physician a director and director and director and the irregularity the (iii) The attending phyresident's medical recirregularity has been action has been taken be no change in their physician should doct the resident's medical section has been taken be no change in their physician should doct the resident's medical section has been taken be no change in their physician should doct the resident's medical section has been taken be no change in their physician should doct the resident's medical section has been taken be no change in their physician should doct the resident's medical section has been taken be no change in their physician should doct the resident's medical section has been taken be no change in their physician should doct the resident's medical section has been taken be no change in their physician should doct the resident's medical section has been taken be no change in their physician should doct the resident's medical section has been taken be no change in the resident's medical section has been taken be no change in the resident's medical recipient has been action has been taken be no change in the resident's medical recipient has been action has been taken be no change in the resident's medical recipient has been action has been taken be no change in the resident has been action has been taken be no change in the resident has been action has been taken be no change in the resident has been action to the resident has been action for the resident has been acti	de, but are not limited to, any riteria set forth in paragraph an unnecessary drug. Noted by the pharmacist ist be documented on a port that is sent to the ind the facility's medical of nursing and lists, at a not's name, the relevant drug, is pharmacist identified. Visician must document in the cord that the identified reviewed and what, if any, in to address it. If there is to medication, the attending ument his or her rationale in I record. Cility must develop and procedures for the monthly that include, but are not is for the different steps in its the pharmacist must take if it is an irregularity that in to protect the resident. To is not met as evidenced in that included time frames indations from the		F756 The pharmacy recommendations for Residents# 44, 41 25, 11, and 8 were completed and signed by the physiciar The facility will adopt a specific policy requiring that pharmacy recommendati will be followed up within 30 days from	ons

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495226	B. WING			C
NAME OF PI	ROVIDER OR SUPPLIER	433220		STREET ADDRESS, CITY, STATE, ZIP CO	•	6/07/2019
MANAGE AND	NUIDOINO AND DELLA	NI ITATION OFNITED		730 LUNENBURG HIGHW		
WAYLANL	NURSING AND REHAE	SILITATION CENTER		KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 756	Continued From pag	e 127	F 75	56		
1 730	#44, #25, #11, and # ensure the Monthly F specified time frames to act upon any phar Resident's #44, #41, The findings include: 1. Resident #44 was 5/8/12 with the diagn severe major depres symptoms, dementia disorder, anxiety dischigh blood pressure, The most recent MD significant change as (Assessment Refere resident was coded a ability to make daily out of a possible 15 of for Mental Status) ex Review of the clinical recommendation dat of the dose of Buspathree times daily to 2 physician disagreed and signed it on 3/8/ Review of the clinical recommendation dat of the dose of Protor mg daily. They physician disagreed and signed it on 3/8/	8. The facility staff failed to Regimen Review policy in which the physician was macy recommendations for #25, #11, and #8. 8 admitted to the facility on loses of but not limited to sion with psychotic with behavior, bipolar order, psychotic disorder, diabetes, and cataracts. S (Minimum Data Set) was a sessment with an ARD noce Date) of 5/16/19. The last being cognitively intact in life decisions, scoring a 14 on the BIMS (Brief Interview fam. I record revealed a pharmacy led 2/28/19 for the reduction of (1) from 5 mg (milligrams) in this recommendation in (2) from 40 mg daily to 20 dician agreed with this		time of receipt. This policy we reviewed and signed by the Medical Director and consul Pharmacist. An in-service education will with the DON and her admir to ensure compliance with the Documentation of compliance recorded in the resident of reviewed by the consulting peach month.	facility, ting be conducted histrative staff his new policy be will be chart and	
	Pharmacist's Respor	y policy, "Consultant nsibilities" failed to reveal any s in which the physician must				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495226	B. WING		C 06/07/2019		
	ROVIDER OR SUPPLIER NURSING AND REHAE			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDERSON CROSS-REFERENCED TO THE APPROPRIES OF T	JLD BE COMPLETION		
F 756	Continued From pag		F 75	56			
	Staff Member - the A Director of Nursing) Consultant) were not regarding the policy which the physician is pharmacy recommer would look and see very 6/7/19 at 8:00 AM, A does not have any or She reviewed the postated that it did not stated that it did	ov/druginfo/meds/a688005.h I to treat gastroesophageal from ov/druginfo/meds/a601246.h s admitted to the facility on moses of but not limited to ure, diabetes, high blood order, breast cancer, bladder tion, congestive heart failure,					
	change assessment Reference Date) of 5	with an ARD (Assessment 5/3/19. The resident was erately impaired in ability to					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		DATE SURVEY COMPLETED	
		495226	B. WING _			C 06/07/2019	
	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			00/01/2013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDEPICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 756	Continued From page	ge 129	F 7	56			
	recommendation da of the use of Paxil (daily to 10 mg daily signed it on 3/8/19. Review of the clinical recommendation day of Vitamin C (2) (do recommendation do wound healing, has could the Vit C be sagreed and signed in A review of the facil Pharmacist's Response specified time frame act upon pharmacy On 6/6/19 at 7:43 P Staff Member - the A Director of Nursing) Consultant) were not regarding the policy which the physician pharmacy recommendation days and the state of the physician pharmacy recommendation days and the state of t	ity policy, "Consultant onsibilities" failed to reveal any es in which the physician must					
	does not have any of She reviewed the per noted that it did not (1) Paxil - is used to disorder, social anx	ASM #4 stated that the facility other policies on the matter. Dlicy that was provided and specify required time frames. In treat depression, panic liety disorder, ye disorder, generalized					
	anxiety disorder, po	st traumatic stress disorder, ric disorder, and hot flashes					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED				
		495226	B. WING _			C 06/07/2019	
	ROVIDER OR SUPPLIER NURSING AND REHA	ABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			000000	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 756	Continued From pa	ge 130	F 7	756			
	Information obtaine https://medlineplus.tml	d from gov/druginfo/meds/a698032.h					
	your skin, bones, a						
	7/30/18 with the dia congestive heart fa blood pressure, frac dementia, depressi osteoarthritis. The Data Set) was an a ARD (Assessment	as admitted to the facility on agnoses of but not limited to allure, atrial fibrillation, high ctured humerus, stroke, on, pulmonary embolism, and most recent MDS (Minimum annual assessment with an Reference Date) of 5/26/19. Oded as moderately impaired ally life decisions.					
	recommendation da of the dose of Proto mg daily. They phy	al record revealed a pharmacy ated 4/26/19 for the reduction onix (1) from 40 mg daily to 20 sician agreed with this and signed it on 5/4/19.					
	Pharmacist's Response	ity policy, "Consultant onsibilities" failed to reveal any es in which the physician must recommendations.					
	Staff Member - the Director of Nursing) Consultant) were no	M, ASM #1 (Administrative Administrator), ASM #2 (the and ASM #4 (Facility Nurse otified of the concerns on to specifying a time frame in					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE C AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495226	B. WING		C 06/07/2019
	ROVIDER OR SUPPLIER O NURSING AND REHA	ABILITATION CENTER		00/07/2013	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 756	pharmacy recomm would look and see 6/7/19 at 8:00 AM, does not have any She reviewed the protect that it did no (1) Protonix - is use reflux.	n is required to act upon endations. ASM #4 stated she what else they have. On SAM #4 stated that the facility other policies on the matter. policy that was provided and t specify required time frames.	F 75	56	
	1/29/19 with the diacongestive heart fakidney disease, go rhabdomyolysis, sy defibrillator, contrarprostate disorder, a recent MDS (Minimassessment with a Reference Date) of coded as being semake daily life decimals are commendation of that Resident #11 (milligrams) every The recommendation is redicare and Med assessment of risk indicate which of the standard properties	vncope, implanted cardiac ctures of bilateral knees, and uropathy reflux. The most num Data Set) was a quarterly in ARD (Assessment f 6/3/19. The resident was verely impaired in ability to			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B. WING				C 07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAE	BILITATION CENTER		730	REET ADDRESS, CITY, STATE, ZIP CODE LUNENBURG HIGHW YSVILLE, VA 23947	1 00/	01/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	and is experiencing repending the benefits outweigh the is used for this reside effect from this medical alternative therapy is therapy is warranted Benefits outs for this resident. Will resident's response. The physician chose "#1 applies." The physician chose "#1 applies." The phyrecommendation on Further review of the pharmacy recommendation on Further review of the pharmacy recommendation on Coursider updating chindication(s) or discolonger required. Col Neurontin (3) Indicat documented, "constituted Colace and "periphe the Neurontin and signification (s) or discolonger required. Col Neurontin (3) Indicat documented, "constituted Colace and "periphe the Neurontin and signification (s) or discolonger required. Colace and "periphe the Neurontin and signification (s) or discolonger required. Colace and "periphe the Neurontin and signification (s) or discolonger required. Colace and "periphe the Neurontin and signification (s) or discolonger required. Colace and "periphe the Neurontin and signification (s) or discolonger required. Colace and "periphe the Neurontin and signification (s) or discolonger required. Colonger required	responding to this medication no adverse effects. The erisks when this medication ent. 2. Possible adverse cation have been noted, but as failed or continued for the following reason: weigh the risks at this time I continue to monitor the 3. Discontinue medication at I below." option 1 and documented, ysician signed this 4/6/19. clinical record revealed a andation dated 2/27/19 that dication(s) for use are led chart records. Please art records with supporting ntinue medication(s) if no ace (2) Indication: The physician pation" on the line for the ral neuropathy" on the line for gned the recommendation on y policy, "Consultant asibilities" failed to reveal any is in which the physician must	F	756			
	Director of Nursing) a Consultant) were not	and ASM #4 (Facility Nurse ified of the concerns					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495226	B. WING		C 06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHA			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	00/07/2019
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 756	which the physician pharmacy recomme will look and see wh at 8:00 AM, ASM #4 not have any other previewed the policy that it did not specify (1) Benadryl - is use itchy, watery eyes; scaused by hay fever coldis also used to minor throat or airwa prevent and treat movements in people parkinsonian syndro Information obtained https://medlineplus.gtml (2) Colace - is used Information obtained https://medlineplus.gtml (3) Neurontin - is used neuropathy, hot flas of breast cancer or information obtained neuropathy, hot flas of breast cancer or information obtained of the present cancer or information obtained the present cancer or information cancer or information cancer or information cancer or	not specifying a time frame in is required to act upon adations. ASM #4 stated she at else they have. On 6/7/19 stated that the facility does policies on the matter. She that was provided and noted a required time frames. If the common to relieve red, irritated, aneezing; and runny nose and irritation is also used to potion sickness, and to treat sed to control abnormal e who have early stage me" If from gov/druginfo/meds/a682539.h If to treat constipation. If from gov/druginfo/meds/a601113.ht and to treat seizures, and to treat seg syndrome, diabetic thes related to the treatment related to menopause.	F 75	56	
		admitted to the facility on agnoses of but not limited to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B. WING				C
	ROVIDER OR SUPPLIER D NURSING AND REHAI			730 L	ET ADDRESS, CITY, STATE, ZIP CODE UNENBURG HIGHW SVILLE, VA 23947	06	/07/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	neuropathic bladder, obstructive uropathy chronic kidney disead diabetes, depression disease, morbid obe most recent MDS (M quarterly assessmer Reference Date) of 3 coded as being mod make daily life decis Review of the clinical recommendation data registered dietician of documented that one as weekly monitoring recommendation on Review of the clinical registered dietician of agreed and signed the signed and signe	hemiplegia, heart failure, respiratory failure, arthritis, se, high blood pressure, peripheral vascular sity, and dysphagia. The linimum Data Set) was a sit with an ARD (Assessment S/12/19. The resident was erately impaired in ability to ions. If record revealed a pharmacy sed 3/27/19 requesting a consult. The physician signed this 4/6/19. If record revealed a pharmacy sed 12/26/18 requesting a consult. The physician nis recommendation on recommendation as well.) If record revealed a pharmacy sed 12/26/18 for the reduction mg (milligrams) daily to 50 cian agreed and signed this 1/2/19. If record revealed a pharmacy sed 12/26/18 for the cessation se recommendation was for wound healing, has and could the Vit C be sician agreed and signed this	F	756			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495226	B. WING		C 06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	1 00/07/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 756	Pharmacist's Respon specified time frames act upon pharmacy recompleted of the policy	sibilities" failed to reveal any in which the physician must ecommendations. ASM #1 (Administrative diministrator), ASM #2 (the and ASM #4 (Facility Nurse fied of the concerns of specifying a time frame in a required to act upon dations. ASM #4 stated she that else they have. On SM #4 stated that the facility her policies on the matter. The policies on the matter are that was provided and decify required time frames. Attreat depression, panic they disorder, generalized traumatic stress disorder, whoric disorder.	F 756		
F 757 SS=D	your skin, bones, and promotes healing and Information obtained https://medlineplus.go Drug Regimen is Free	I helps the body absorb iron. from ov/vitaminc.html e from Unnecessary Drugs -(6)	F 757	,	7/21/19
		regimen must be free from An unnecessary drug is any			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495226	B. WING				07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER	-	73	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW EYSVILLE, VA 23947	1 001	0772013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757	Continued From page	e 136	F	757			
	§483.45(d)(1) In exce duplicate drug therap	essive dose (including y); or					
	§483.45(d)(2) For exc	cessive duration; or					
	§483.45(d)(3) Withou	t adequate monitoring; or					
	§483.45(d)(4) Without use; or	t adequate indications for its					
	§483.45(d)(5) In the process which reduced or discontinu	indicate the dose should be					
	stated in paragraphs section.	mbinations of the reasons (d)(1) through (5) of this is not met as evidenced					
	Based on staff intervand clinical record refacility staff failed to ethe survey sample was medications, Resider				F-757 The charge nurse for resident #33 was re-educated on the current physician order and the necessity to monitor and record the blood pressure and pulse of Resident #33 prior to the administration blood pressure medication. Resident #33 was found to be the only resident that was out of compliance with	n of	
	5/1/19 with diagnoses limited to: dementia, diabetes, stroke and pulmonary disease -	COPD (chronic obstructive general term for chronic, sease that is usually a			the order involving blood pressure medication Nursing staff will be re-educated on the necessity of following physician orders especially when the order gives specifiparameters. The DON or her designee will review the documentation weekly on those resides specifically having orders with specific parameters to ensure continued	e c	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		405000	D WING				С	
		495226	B. WING _			06/	07/2019	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
WAVI AND	NURSING AND REHAB	II ITATION CENTER		73	30 LUNENBURG HIGHW			
WAILAND	NORSING AND REHAB	ILITATION CENTER		K	EYSVILLE, VA 23947			
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI		x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 757	assessment reference resident as scoring a interview for mental sis severely impaired to decisions. The physician order of "Metoprolol Tartrate (pressure) (2), 25 mg by mouth twice daily, pressure) less than 1 than 50." The May MAR (medic documented the above order. On the following pressure/pulse was nadministration of the 15/8/19 at 9:00 a.m 15/10/19 at 9:00 p.m 15/11/19 at 9:00 p.m 15/12/19 at 9:00 p.m 15/12/19 at 9:00 p.m 15/20/19 at 9:00 p.m 15/21/19 at 9:0		F	757	compliance. Results of these reviews we be submitted to the Cardinal IDT members for oversight and review. The QAPI committee will incorporate any findings of non-compliance and make further recommendations.			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495226	B. WING _			C 06/07/2019	
	ROVIDER OR SUPPLIER NURSING AND REHA	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	•	30.02010	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 757	was documented 5/29/19 at 9:00 p.m was documented 5/30/19 at 9:00 p.m was documented. Review of the nurse dates and times fai of the missing blood the vital signs tab in failed to evidence the pressure readings. The comprehensive documented in particular, arterioscleror retinopathy." The "I part, "Monitor blood and/or as ordered to the pressure readings. An interview was concepted and pressure to the pressure readings. An interview was concepted to the pressure readings.	a no blood pressure or pulse b no blood pressure or pulse c no pulse was documented c no pulse or blood pressure ce's notes for the above listed ded to evidence documentation ded pressure or pulse. Review of the computerized record, the missing pulse or blood ce care plan dated, 5/3/19, the pulse of the pulse of the complications of renal totic disease and/or the pressure per facility protocol	F7	757			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495226	B. WING			C 06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAI	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	<u> </u>	50/07/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 757	there is no document pressure on some doorder does say 'or." The policy "Medicati documented in part, following principles says the same of the same	oulse." When asked why tation of a pulse or blood ays, ASM #2 stated, "Well the on Administration" "N. Any deviation from the	F 79	57		
	right dose. 4. By the method. 6. At the rig document any menti prescribed vital signs medication.	s prior to administration of a				
	to determine your re doctor may ask you rate). Ask your phan how to take your pul slower than it should	e should be checked regularly sponse to metoprolol. Your to check your pulse (heart macist or doctor to teach you se. If your pulse is faster or lebe, call your doctor." (2).				
	facility nurse consult above findings on 6/					
F 758	(1) Barron's Dictional Non-Medical Reader Chapman, page 124 (2) This information following website: https://medlineplus.gtml.	ary of Medical Terms for the forth edition, Rothenberg and was obtained from the mov/druginfo/meds/a682864.h	F 79	58		7/21/19
SS=E	CFR(s): 483.45(c)(3	•		טכ		1121/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495226	B. WING				07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW EYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	affects brain activities processes and behave but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehe resident, the facility management of the second of the se	ppic Drugs. hotropic drug is any drug that associated with mental rior. These drugs include, drugs in the following ensive assessment of a must ensure that must who have not used re not given these drugs is necessary to treat a diagnosed and documented ints who use psychotropic I dose reductions, and must ensure that ints who use psychotropic I dose reductions, and must ensure these ints do not receive cursuant to a PRN order is necessary to treat a sondition that is documented and rders for psychotropic drugs is Except as provided in attending physician or	F	758			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION B		PLETED
		495226	B. WING			C 07/2019
	ROVIDER OR SUPPLIER NURSING AND REHA			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	1 06/	0112019
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 758	rationale in the resident indicate the duration should be shown in the resident indicate the duration should be shou	or she should document their ent's medical record and for the PRN order. orders for anti-psychotic 14 days and cannot be attending physician or her evaluates the resident for of that medication. T is not met as evidenced on, clinical record review, acility document review, it the facility staff failed to re free of unnecessary ations for one of 6 residents in nistration observation for two of 33 residents in the	F 75	F-758 The Nursing staff was re-educated ophysician orders, necessity of documentation, and requirements for identifications of targeted behaviors Residents #44 and 34. No other residents were identified a being out of compliance with documentation. A review of policy and procedures for	or on S	
	indications prior to a (prn) antipsychotic r Resident #44. Staff Resident #44 for conwas not a document administration of the attempting non-phaned. The facility staff faindications for the action (PRN) Risperdal and failed to administer the physician of the facility staff failed. The facility staff failed to administer the physician of the facility staff failed.	medication and without macological interventions. miled to ensure adequate diministration of as needed antipsychotic medication and he medication to Resident n's orders. miled to ensure targeted tified, documented and		medications and documentation requirements will be conducted. Stathen receive education regarding Pf documentation and the proper areas document targeted behaviors. Grad Dose Reductions and physician documentation of continued medical usage will be covered. The DON or her designee will condumentally review of physician orders identify GDRs and PRN medications within the facility. Residents identifications within the facility. Residents identifications with the secategories will be monitored by Cardinal IDT in its morning meeting ensure compliance with regulations. Medical Director will receive a report the IDT findings at the Monthly QAF meeting and will make suggestions	aff will RN s to ual tion act a o s ed in by the s to The t of	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION G		TE SURVEY MPLETED
		495226	B. WING			C
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		6/07/2019
WAYLAND	NURSING AND REHAB	ILITATION CENTER		730 LUNENBURG HIGHW KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 758	Continued From page	e 142	F 75	58		
	antipsychotic medicat #34.	ion Seroquel to Resident		needed		
	The findings include:					
	indications prior to ad (prn) antipsychotic me Resident #44. Staff and Resident #44 for come was not a documente administration of the lattempting non-pharm Resident #44 was add 5/8/12 with the diagnous severe major depress	medication and without nacological interventions. mitted to the facility on ones of but not limited to				
	disorder, anxiety diso high blood pressure, The most recent MDS significant change as (Assessment Referent resident was coded a ability to make daily li	rder, psychotic disorder, diabetes, and cataracts. (Minimum Data Set) was a sessment with an ARD ace Date) of 5/16/19. The s being cognitively intact in fe decisions, scoring a 14 n the BIMS (Brief Interview				
	0.5 mg (milligrams) bineeded) for agitation is not an approved us On 6/05/19 08:24 AM	ed 5/20/19 for Risperdal (1) d (twice daily) prn (as and bipolar. (Note: Anxiety e for Risperdal). , LPN #1 was observed to				
	prepare and administ to Resident #44: Zaditor (2) eye drops,	er the following medications 1 drop in each eye				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B. WING _			C 06/07/2019	
	ROVIDER OR SUPPLIER D NURSING AND REHA	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		90,01,2010	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 758	Continued From pa	ge 143	F 7	758			
	Miralax (3) 17 gram Voltaren gel (4), ap Depakote (5) sprint 2 tabs (tablets) Calcium (6) 250mg gave 1 tab Risperdal 0.5 mg p gave 1 tab. At this time, she as needed her "mediciresident stated she appear anxious or a her wheelchair and were no apparent stabent's Risperdadrawer. As she waresident it was for hwith the resident to medications. She applied the Voltarel She then assisted the wheelchair, and addrops and then gave pills, including the finedications, LPN finedications, LPN finedications, LPN finedications, LPN finedications of the resident had resi	is .					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILD	NG _		، ا	С
		495226	B. WING				07/2019
	ROVIDER OR SUPPLIER	ABILITATION CENTER	•		STREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW	•	
WAILAND	NORONO AND KEN	ABIETIATION GENTER		K	KEYSVILLE, VA 23947		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 758	stated it was. When order stated it was unable to show that anxiety. When ask non-pharmacological administering their the resident was acclothes being twist assisted her with reinformed of the obsishowing any signs medication cart at the Risperdal withor-pharmacological in that she had repositing (in her room worder Voltaren gel to her (after administering of the issues the rewas tired. When it additional intervent conjunction with or and not before, LP asked for the medication with the medication of the issues the rewastired. LPN #1 wastaff follows for det PRN (as needed) restaff should try to fi wants the medication might be apharmacological in medication only aftineffective.	as ordered for anxiety, LPN #1 as asked to show where the for anxiety, LPN #1 was at the Risperdal was ordered for ked about offering cal interventions prior to nedication, LPN #1 stated that gitated earlier about her ed and bunched up and she eadjusting her clothes. When servation of the resident not of anxiety or agitation, at the 8:24 AM, and still being offered out offering non interventions. LPN #1 stated itioned her clothes a second with the administration of knees) and assisted her to bed g all medications) because one esident expressed was that she was noted that these tions were done only in after providing the medication, N #1 stated the resident had cation and it was her right to as asked about the process the termining if a resident needs a medication. LPN #1 stated that figure out why the resident on, try to fix whatever the by offering non terventions, and give the ter other attempts are	F	758			
	reveal any nurses of the resident's an	ne clinical record failed to notes documenting the nature exiety and agitation or any cal interventions attempted. A					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	l' '		ATE SURVEY MPLETED
		495226	B. WING		١,	C 06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CO 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		36/07/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 758	review of the back of Administration Record Resident #44 reveale administered for "resi anxiousness." On 6/06/19 at 7:11 PI #4, she stated that Riused for aggressive be is not used for anxiety not give a resident Rianxiety. She stated the need to be combative exhibiting some type stated she would not not showing these sy the care plan was not Risperdal was given to A review of the comparevealed one for "Proresident acts characted verbal/ physical Aggrerelated to: Cognitive in changes in the brain." 2/8/18. The intervent 2/8/18 for "Monitor are facility protocol" and comedication as prescriand one dated 3/25/1 anxiety per facility protocol and comedicated dated 6/5/12 documed drugs with the potentiside effects due to us antidepressants, antifedocumented the intervented and comedication and the potentiside effects due to us antidepressants, antifedocumented the intervented the inter	the MAR (Medication d) for June 2019 for d the Risperdal was dent request for M, in an interview with LPN sperdal is an antipsychotic behaviors. She stated that it y. She stated that she would sperdal if they say they have that to give it, there would so or aggressive behaviors or of psychotic behaviors. She give it if the resident were mptoms. She stated that it followed because the for the wrong reason. The sident were plan blematic manner in which erized by ineffective coping: the ession or Combativeness mpairments/phys (physical) in This care plan was dated in document behavior per one dated 5/31/18 for "Give bed by MD (medical doctor); 9 for "Document episodes of obtocol and notify MD of ." In addition, a care plan inted, "Use of psychotropic al for or characterized by	F	758		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED
		495226	B. WING		C 06/07/2019
	ROVIDER OR SUPPLIER D NURSING AND REHAI			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	00/07/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 758	Therapy" documente encourage appropria drugs2. To provide resident receiving suadverse consequence in achieving therape encourage the use of to and, if indicated, if antipsychotic drug the other pharmacologic possible" On 6/6/19 at 7:43 PN Staff Member - the ADirector of Nursing) Consultant) were no further information wasurvey. (1) Risperdal - is an treat schizophrenia, episodes, and behave Information obtained that the itching of Information obtained that ps://medlineplus.gotml (2) Zaditor - is an op relieve the itching of Information obtained that ps://medlineplus.gotml (3) Miralax - is used Information obtained that ps://medlineplus.gotml	ty policy, "Antipsychotic Drug ed, "A. Purpose: 1. To ate utilization of antipsychotic er for the monitoring of the arch drugs for possible ces and to measure progress utic objectives. 3. To af non-drug interventions prior in conjunction with merapy as well as the use of earl interventions when and ASM #1 (Administrative administrator), ASM #2 (the and ASM #4 (Facility Nurse tified of the concerns. No eas provided by the end of the antipsychotic and is used to mania, mixed mood viors. I from gov/druginfo/meds/a694015.h thalmic solution used to allergic pinkeye. I from gov/druginfo/meds/a604033.h to treat constipation.	F 75		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495226	B. WING		C 06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHA			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	00/07/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 758	ml (5) Depakote - is use bipolar disorder. Information obtained https://medlineplus.gtml (6) Calcium - Calcium foods. The body nees strong bones and to functions. Almost all and teeth, where it is hardness. The body muscles to move an messages between part. In addition, calcivessels move blood help release hormor almost every function Information obtained https://ods.od.nih.gomer/ 2. The facility staff faindications for the action (PRN) Risperdal an failed to administer the physicial Resident #44 was action 5/8/12 with a recent diagnoses that include depression, diabeted [a mental disorder comania and depression]	I from gov/druginfo/meds/a611002.ht ed to treat seizures and a from gov/druginfo/meds/a682412.h em is a mineral found in many eds calcium to maintain carry out many important calcium is stored in bones upports their structure and edical and every body cium is used to help blood throughout the body and to less and enzymes that affect in in the human body. I from ev/factsheets/Calcium-Consumiled to ensure adequate diministration of as needed antipsychotic medication and he medication to Resident	F 758		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	\ , ,	TE SURVEY MPLETED
		495226	B. WING _			C 6/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		0/01/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 758	Continued From page	e 148	F 7	58		
		nges in the joints, pain, g can develop after exercise				
	assessment, a signification with an assessment of coded the resident as (brief interview for me the resident was cap cognitive decisions. requiring extensive a member for most of his Section N - Medication as having received a on four days during the period. The physician order of "Risperdal [used to the bipolar disease (3)], of po (by mouth) BID (to for agitation." The nurse practitioned documented in part, was changed from the	The resident was coded as ssistance of one staff ner activities of daily living. In ons, the resident was coded in antipsychotic medication the last seven-day look back dated, 5/15/19, documented, reat schizophrenia and 0.5 mg (milligrams) 1 (tablet) wice a day) PRN (as needed) er note dated, 5/18/19, "Her risperidone (Risperdal) vice a day on a scheduled as needed for agitation."				
	evidence documenta the continued use of medication by the att nurse practitioner. As 6/7/19, 23 days after needed (PRN) Rispe	tion evidencing the need for				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVE COMPLETED	
		495226	B. WING _			C 06/07/20	119
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	00/01/20	,10
WAYLAND	NURSING AND REHAB	ILITATION CENTER		730 LUNENBURG HIGHW			
				KEYSVILLE, VA 23947			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIA	COM	(X5) IPLETION DATE
F 758	Continued From page	e 149	F 7	758			
	record) documented. The medication was 5/25/19 at 6:00 p.m. so nurse's notes failed to documentation on 5/2 administration of the. The June 2019 MAR physicians order. The documented as giver 6/4/19 at 6:30 a.m. for nurse's notes for the evidence any documented.	25/19 regarding the above medication. documented the above emedication was a on 6/3/19 at 6:00 p.m. and or "anxiety." Review of the					
	documented in part, in which resident acts coping; verbal/physic combativeness related impairment/physical of "Interventions" document behavior pulan dated, 5/31/18, for Problematic manner characterized by inef Agitation/Combativer effects, frustration." If documented in part, in prescribed by MD (m document behaviors An interview was contacted in part, of director of nursing, or combative staff of the combative staff of director of nursing, or combative staff of the combative staff of th	ed to: cognitive changes in brain." The mented in part, "Monitor and er facility protocol." The care further documented, "Focus: in which resident acts fective coping; mess related to: Drug side The "Interventions" "Give medication as edical doctor). Monitor and per facility protocol.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		(X3) DATE S COMPL	
		495226	B. WING _			06/0) 7/2019
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	DE	1 00/0	7772013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 758	could be administeree "I don't think so." Who antipsychotic medical stated, "It's based on practitioner) wants us if an as needed antipreviewed periodically continued use. ASM reviews the medication recommendations on asked if she was awaregarding the use of limedications, ASM #3	ove for agitation was 3. When asked if Risperdal d for anxiety, ASM #3 stated, en asked how often are PRN tions are renewed, ASM #3 what (name of nurse to do." ASM #3 was asked sychotic medication is to evaluate to need for #3 stated, "The pharmacist ons and makes a monthly basis." When are of the regulation PRN antipsychotic e stated, "No, I am not."	F 7	758			
	director of nursing; or #2 was asked to revie asked the nurses give for anxiety when the ASM #2 stated, "Anxi agitation." ASM #2 st practitioners don't like medications around. who was just readmit after a psychiatric add 4/11/19, has been se services, ASM #2 stathat. On 6/6/19 at app #2 presented the psy one was dated 3/25/14. An interview was confacility nurse consultation when asked if there a for the use of a PRN	When asked if the resident, ted on 5/9/19, to the facility mission to the hospital on en by the facility psychiatric ted she's have to look into proximately 4:45 p.m., ASM chiatric consults. The last					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	RUCTION (X3) DATE COM	
		495226	B. WING _			C 06/07/2019
	ROVIDER OR SUPPLIER NURSING AND REHA	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	•	00/07/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 758	Continued From pag	ge 151	F 7	58		
	•	reevaluated and has to be thorough evaluation by the				
	member (OSM) #7, consultant, on 6/7/1 PRN (as needed) ar be used in a facility, 14 day period that the 14 days they have the physician and docur use." The facility policy, "A failed to evidence defined to	nducted with other staff the facility pharmacy 9 at 9:32 a.m. When asked if ntipsychotics are allowed to OSM #7 stated, "There is a ney can be used but after that to be reevaluated by the mentation of their continued Antipsychotic Drug Therapy" ocumentation related to the chotic medications and their				
	of nursing, and ASM consultant, were ma findings on 6/6/19 a	strator, ASM #2, the director I #4, the facility nurse ide aware of the above t 7:35 p.m.				
	Non-Medical Reade Chapman, page 72. (2) Barron's Dictiona Non-Medical Reade Chapman, page 422 (3) This information following website:	ary of Medical Terms for the r, 5th edition, Rothenberg and ary of Medical Terms for the r, 5th edition, Rothenberg and 2. was obtained from the gov/druginfo/meds/a694015.h				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	[` ´c		SURVEY LETED
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	ROVIDER OR SUPPLIER D NURSING AND REHAI	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	CODE	1 00/0	7772013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD B THE APPROPRIA		(X5) COMPLETION DATE
F 758	behaviors were iden monitored for the ad antipsychotic medica #34. Resident #34 was ad 10/17/17 with diagnous not limited to: diabet stroke, high blood president has sessment, a quart assessment reference resident as scoring interview for mental resident was severed cognitive decisions. The MDS assessment section E - Behavior as having any behavior and as not has the MDS assessment with an assessment documented in Section E of the MDS assessment documented in Section E of the most section E of the MDS assessment documented in Section E of the resident as	dilled to ensure targeted tified, documented and ministration of the ation Seroquel to Resident dimitted to the facility on oses that included but were es, dementia, depression, essure, and bradycardia (A or than 60 in adults) (1). S (minimum data set) erly assessment, with an or date of 5/10/19, coded the 3" on the BIMS (brief status) score, indicating the ly impaired to make daily In Section E - Behaviors, the led as having any behaviors period and as not having	F 7	758			
	I .	nt, an annual assessment, reference date of 8/31/18,					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495226	B. WING				07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAB	ILITATION CENTER	•	73	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW EYSVILLE, VA 23947	1 001	0172010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 758		e 153 on E - Behaviors, did not having any behaviors during	F	758			
	the look back period a of psychosis.	and as not having indicators					
	"Seroquel (Quetiaping schizophrenia and ald depression (2)] tab (ta	dated, 8/20/18, documented, e-generic) [used to treat ong with other medications, ablet) 25 mg (milligrams) 1/2 every night at bedtime for					
	the above physician r	ration record) documented nedication order and ication was administered					
	(resident representation resident's feet. Areas the cream however, hallow it to be put on. "2/2/19 at 10:45 p.m. memory loss. Wants eats supper. Staff hat that we are in the micother residents. Residentinutes later will be a wants to go to bed. Want drinks from home supper. "2/13/19 at 2:51 p.m. RR about resident res	- message left for RR ve) regarding condition of remain dry continuing with the frequently refused to Resident has short term to go to bed as soon as he as to remind him every night aldle of supper and feeding dent will say OK, then a few stalling for help. Is saying he define him eats before Nurse called and spoke with fusal with shaving. She liready brought razor up to					

AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION		TE SURVEY MPLETED
		495226	B. WING			C 6/07/2019
	OVIDER OR SUPPLIER NURSING AND REHAE			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	1 0	0/07/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	no BM (bowel moven administer MOM (mil stated, 'I'm not taking refuse. "3/6/19 at 2:38 p.m. F taking MOM x3 day or refusal of shower. "3/7/19 at 6:20 a.m. F assistant) resident remorning, writer offere "3/15/19 at 10:06 a.m nurse attempted to a refused. "3/30/19 at 8:41 a.m. "4/8/19 at 12:02 p.m. x 3 days, would only [milliliters]) of MOM of "4/8/19 at 7:00 p.m. F to be lifted by CNA w supervision. "4/18/19 at 2:08 p.m. x 3 days, resident or centimeters) MOM. "4/22/19 at 11:08 a.m BM x3 days, resident protocol. "4/24/19 at 5:52 a.m. bowel movement in the refusal of MOM. "5/15/19 at 5:51 a.m. x3 days, MOM refuse "5/17/19 at 10:29 a.m BM x 3 days. MOM g take apprx (approximate centimeters).	n. Resident flagging x 3days ment). Nurse attempted to k of magnesia) and resident to that.' Resident continues to that.' Resident continues to that.' Resident continues to that.' Resident continues to that.' Resident refusal of the total continues to the total continues to that.' Resident refusal of the total continues to the shaved this end to so still resident refused. In a Flagging x3 days no BM. It is defented that the total continues to the total co	F 75	8		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495226	B. WING			1	C 07/2019
	ROVIDER OR SUPPLIER NURSING AND REHAE	BILITATION CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW EYSVILLE, VA 23947	1 00/	0772013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From pag	e 155	F	758			
	understand who I am documentation regar	hiatric): he is pleasant and as the doctor. No other ding his mood or behaviors.					
		ated, 12/3/18, failed to tion related to mood or					
		ated, 4/1/19, failed to entation related to mood or					
	documented in part, depression. Review						
	documented in part, depression. Review of mood swings, increa ideations. Physical E	er note dated, 2/22/19, "Past Medical History - of Systems: Psychiatric - no sed nervousness or suicidal exam: Psychiatric - Mood and lent oriented to person and					
	documented in part, compliance with his re (Resident #34) has dirritability, mood swin motivation. She report medication and coop denies any suicidal ideationsPast Medications of Systems: cognition or increase	er note dated, 5/30/19 "His nurse reports resident medication and diet lepression. His nurse reports ags and decreased rts he is compliant with his erative with his care. He deations or homicidal ical History - Depression. Psychiatric: no changes in d nervousnessPhysical lood and affect flat; resident					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	COMF	(X3) DATE SURVEY COMPLETED		
		495226	B. WING			C 07/2019	
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947	j 06/	0//2019	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 758	documented in part, in which resident accoping; verbal/physicombativeness relat "Interventions" document behavior facility protocol." The documented, "Focus which resident acts coping; Sleeplessnerestlessness." The "part, "Administer me pattern and quality cepisodes, and notify possible intervention plan documented "Forugs with the POTE by SIDE EFFECTS gastrointestinal systor/due to diagnoses antidepressant (GDI antipsychotic 7/6/18 documented, "Administer Total Company of the Potential Systory of the potential syst	care plan dated, 10/22/18 "Focus: Problematic manner is characterized by ineffective cal aggression or ed to: anger." The mented in part, "Monitor and (physical) behaviors) per e care plan further is: Problematic manner in characterized by ineffective ss/insomnia related to: Interventions" documented in indication. Monitor sleep of sleep/rest, document physician of changes for its as appropriate." The care ocus: Use of psychoactive ENTIAL FOR or characterized of cardiac, neuromuscular, ems AEB (as exhibited by)	F 75	,			
	practical nurse) #2 c asked where behavi stated, on the back of administration recon LPN #2 was asked we behaviors are for the stated, "When he first been cut back. His we	n ongoing basis." Inducted with LPN (Licensed on 6/5/19 at 5:43 p.m. When ors are documented, LPN #2 of the MAR (medication d) and in the progress notes." What Resident #34's targeted e use of Seroquel. LPN #2 of came he was on it but it's wife said he took it at home to ly his behaviors are much					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495226	B. WING _			C 06/07/2019			
	ROVIDER OR SUPPLIER D NURSING AND REHAE	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			<u> </u>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	-	(X5) MPLETION DATE
F 758	document it if she sal behavior or somethin An interview was connurse) #2, on 6/5/19 where behaviors are in the computer undeasked what the targe #34 are for the use of don't know." An interview was con (administrative staff nursing, on 6/5/19 at about the process for resident behaviors, Abe in the progress no behavior." ASM #2 w #34's targeted behav Seroquel. ASM #2 st	ked when she would r, LPN #2 stated she's w the resident having a g that is out of their norm." Iducted with RN (registered at 5:45 p.m. When asked documented, RN #2 stated er behavior notes. When ted behaviors for Resident f Seroquel, RN #2 stated, "I	F 7	,					
	ASM #5, the nurse pra.m. When asked the on Seroquel, ASM # and depression." Whe clinical record documdepression/insomnia resident has been masince admission. (10, insomnia is an indicastated, "No, it's not." #34's behaviors are fasm #5 stated, "He is behaviors. When asked in the saked in th								

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495226	B. WING _			C 06/07/2019	
	NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		0/07/2019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 758	expect for refusing #5 stated, "I talk to tell me his behavior documentation." V psychiatric services #5 stated, "Yes, b not satisfied with to I am a family nurse practitioner. Get the resident to going to look into services once the a GDR (gradual doutempted, as the documented behaviors return a strength of the services once the a GDR (gradual doutempted, as the documented behaviors return a strength of the services once the a GDR (gradual doutempted but my resident either has behaviors return a strength of the state of nursing #2 was asked if the Resident #34. AS When asked why ASM #2 stated, "Hangry, mad and conductors and nurse change things. He staff." ASM #2 stated, stated she had not for this resident. Stated she had not for this resident. Stated she had not for this resident.	documentation of behaviors, g MOM and to be shaved, ASM of the nurse and CNAs and they ors. I can't control their When asked if there were as available in the building, ASM of the psych (psychiatric) services. Transportation is an issue to an outside psychiatrist. We are getting other psych (psychiatric) survey is over." When asked if ose reduction) should be resident does not have aviors and is on a low dose of a stated, "I guess it can be experience with GDR is that the verto be hospitalized or their and increase." Conducted with ASM #2, the grand increase." Conducted with ASM #2, the grand increase." Conducted with ASM #2, the grand increase." Resident #34 was on Seroquel, the first came here he was very ame from the hospital with it. My a practitioner are hesitant to a was kicking and cursing at the swas kicking and cursing at the swas kicking and cursing at a the swas kicking and cursing at the swas kicking and cursing at the swas kicking and cursing at a the swas kicking and cursing at the swas kicking at the swas kicking at the swas kicking at the swas kickin	F 7	758			

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495226	B. WING			C 06/07/2019	
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL		X (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE	
Review of the clinical any documentation of exhibiting hallucination of exhibiting hallucination. ASM #1, the administ of nursing, and ASM aconsultant were made concern on 6/6/19 at the No further information. (1) Barron's Dictionar Non-Medical Reader, Chapman, page 87. (2) This information of following website: https://medlineplus.gottml. Infection Prevention & CFR(s): 483.80(a)(1)(a) §483.80 Infection Control facility must estate infection prevention adesigned to provide a comfortable environmed development and transitional development and transitional development and transitional development and transitional facility must estate and control program. The facility must estate and control program (a minimum, the follower.)	record failed to evidence f Resident #34 having or ns. rator, ASM #2, the director #4, the facility nurse e aware of the above 7:35 p.m. n was provided prior to exit. y of Medical Terms for the 5th edition, Rothenberg and ras obtained from the ov/druginfo/meds/a698019.h & Control (2)(4)(e)(f) ntrol blish and maintain an nd control program asafe, sanitary and tent and to help prevent the asmission of communicable ns. orevention and control blish an infection prevention IPCP) that must include, at ring elements:		758		7/21/19	
§483.80(a)(1) A syste	m for preventing, identifying,					
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETTER CONTINUED From pages) Review of the clinical any documentation of exhibiting hallucination of exhibiting hallucination of exhibiting hallucination of nursing, and ASM aconsultant were made concern on 6/6/19 at 10 No further information (1) Barron's Dictionar Non-Medical Reader, Chapman, page 87. (2) This information we following website: https://medlineplus.gottml. Infection Prevention & CFR(s): 483.80(a)(1)(1) §483.80 Infection Control The facility must established infection prevention adesigned to provide a comfortable environmed development and transition development and transition for the facility must established environmed evelopment and transition for the facility must established environmed evelopment and transition for the facility must established environmed evelopment and transition for the facility must established environmed evelopment and transition for the facility must established environmed evelopment and transition for the facility must established environment and control program (a minimum, the follows).	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 159 Review of the clinical record failed to evidence any documentation of Resident #34 having or exhibiting hallucinations. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #4, the facility nurse consultant were made aware of the above concern on 6/6/19 at 7:35 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 87. (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a698019.h tml. Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	A BUILDI A 95226 B. WING ROVIDER OR SUPPLIER NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 159 Review of the clinical record failed to evidence any documentation of Resident #34 having or exhibiting hallucinations. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #4, the facility nurse consultant were made aware of the above concern on 6/6/19 at 7:35 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 87. (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a698019.html. 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In featility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	A BUILDING 49526 B. WING 66 WONDER OR SUPPLIER 730 LUNENBURG HIGHW KEYSVILLE, VA 23947 SUMMARY STATEMENT OF DEFIDIENCES (EACH DEFICIENCY MEDICINE) (EACH DEFICIENCY) Continued From page 159 Review of the clinical record failed to evidence any documentation of Resident #34 having or exhibiting hallucinations. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #4, the facility nurse consultant were made aware of the above concern on 6/6/19 at 7:35 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 87. (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a698019.h tml. 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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
ig, investigation municable of plunteers, vising services under according and national stated according and national stated according and national stated according and invested for the properties of the properties of the properties and to who inicable disearch and to who inicable disearch and how is a type and during upon the districtive possistances, circumstance on the properties of infected significant and hygienes with resident will transmit thand hygienes involved in decay and the properties of the propert	iseases for all residents, tors, and other individuals ander a contractual upon the facility assessment to \$483.70(e) and following andards; In standards, policies, and rogram, which must include, illiance designed to identify ble diseases or y can spread to other (f); Im possible incidents of se or infections should be used for a ut not limited to: ration of the isolation, infectious agent or organism at the isolation should be the ible for the resident under the ses under which the facility rees with a communicable kin lesions from direct to the disease; and a procedures to be followed irect resident contact.	F	380				
	SUMMARY STEACH DEFICIENCE REGULATORY OR SUMMARY STEACH DEFICIENCE AND SUMMARY STEACH DEFINITION OF THE PROPERTY OF THE	IDENTIFICATION NUMBER: 495226 IG AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) LIED From page 160 Ing., investigating, and controlling infections immunicable diseases for all residents, colunteers, visitors, and other individuals ing services under a contractual ement based upon the facility assessment exted according to §483.70(e) and following end national standards; O(a)(2) Written standards, policies, and ures for the program, which must include, not limited to: In the facility; In and to whom possible incidents of incidents of incident and transmission-based precautions ollowed to prevent spread of infections; In and how isolation should be used for a act; including but not limited to: In type and duration of the isolation, ding upon the infectious agent or organism d, and equirement that the isolation should be the estrictive possible for the resident under the	A BUILDIE 495226 B. WING BOR SUPPLIER GAND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FER BUILDIE TAG A BUILDIE TAG ID ID ID ID ID ID ID ID ID I	A BUILDING 495226 B. WING STRET TO AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Led From page 160 Ing. investigating, and controlling infections municable diseases for all residents, oblunteers, visitors, and other individuals agenent based upon the facility assessment eted according to §483.70(e) and following end national standards; O(a)(2) Written standards, policies, and ures for the program, which must include, not limited to: stem of surveillance designed to identify e communicable diseases or ins before they can spread to other is in the facility; en and to whom possible incidents of infections; en and how isolation should be used for a ent; including but not limited to: the type and duration of the isolation, ding upon the infectious agent or organism d, and equirement that the isolation should be the estrictive possible for the resident under the estances. Circumstances under which the facility rohibit employees with a communicable er or infected skin lesions from direct with residents or their food, if direct is will transmit the disease; and hand hygiene procedures to be followed involved in direct resident contact. O(a)(4) A system for recording incidents	TION DENTIFICATION NUMBER: 495226 RESUPPLIER RESUPPLIER SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCY SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCY TAG TO STATEMENT OF DEFICIENCY F 880 F 880	A BUILDING 495226 B. WING TSTREET ADDRESS, CITY, STATE, ZIP CODE 730 LUNENBURG HIGHW KEYSVILLE, VA 23947 SUMMARY STATEMENT OF DEFICIENCIES TAG UNENBBURG HIGHW KEYSVILLE, VA 23947 PROVIDERS FLAND OF CORRECTION FROM CHARLES ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 880 F	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	PLE CONSTRUCTION G	\ , ,	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		06/07/2019	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 880	§483.80(e) Linens Personnel must h transport linens so infection. §483.80(f) Annua The facility will co IPCP and update This REQUIREME by: Based on observ document review was determined th Legionella policy a program, as evide control tracking lo through May 2019 for the months of and failed to follow during medication residents in the m observation, Residunched a pill with administered the in The findings inclu 1. On 6/4/19 at ap entrance to the fa procedure for the the risk of growth other opportunisti systems, was req On 6/6/19 at 2:32	andle, store, process, and as to prevent the spread of review. Induct an annual review of its their program, as necessary. ENT is not met as evidenced ation, staff interview, facility and clinical record review, it ne facility staff failed to have a and a complete infection control enced by a lack of infections gs for the months of April 2019 and incomplete tracking logs. December through March 2019; winfection control practices administration for one of six edication administration dent #41. The facility staff at their bare hands and then medication to Resident #41. de: Deproximately 12:15 p.m., upon cility a copy of the policy and water management to reduce and spread of Legionella and copathogens in the facility water	F 84	F-880 The maintenance person has further training on the facility program. Areas subject to be identified and water test maintained. Infection contrupdated. Staff will receive in service the facility s Infection Contand the requirements there individual RN will be secure the program. Maintenance testing logs for Legionella program will be the maintenance office and the Safety Committee mont control logs will be maintain SDC/IC office and presente to the QA Committee. The QAPI Committee will refrom the Safety Committee Nurse to provide oversight and the Safety Committee.	ty segionella infection will ing logs will be ol logs will be education on trol program of. An ed to administer or the maintained in reported to thly. Infection hed in the ed each month ecceive reports and the IC		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
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F 880	Management Prograding Growth and Spread this was their policy team that he has be maintenance men in maintenance directs building for three we things that are to be corporate office is we getting the Legionel building. On 6/6/19 at 3:32 p survey team and state the maintenance deany documentation any testing that has not locate what are a Legionella program. Administrative staff and ASM #4, the face	titled, "Developing a Water am to Reduce Legionella in Buildings." When asked if ASM #1 informed the survey sen through three different in the past year. His current or has only been in the eek and is learning all of the edone is his department. The working on training him and la program into effect in the eated he has looked through epartment and cannot locate regarding the program and been completed. He could as that would be of concern in	F 8	80				
	2. The facility staff control tracking logs through May 2019 a	failed to have any infections for the months of April 2019 and had incomplete tracking of December through March						
	entrance conference Administrator (ASM Member) and ASM	timately 12:00 PM, an e was conducted with the #1 - Administrative Staff #2 (the Director of Nursing). Il tracking logs for the last 6						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 880	months was request The information provinfection Control Relline-item listing of earlientified infections and Consultant) were not there appeared to be provided. On 6/6/19 at 7:43 PN Staff Member - the ADirector of Nursing) Consultant) were not there appeared to be provided. On 6/7/19 at 8:46 ANDirector of Nursing) tracking logs from Domarch 2019. There infections that were being tracked. There and May 2019 provided "created the logs lass the former infection of longer at the facility, create the logs for AD the former infection of the facility of the facility of the former infection of the facility of t	rided was a "Monthly port" which was not a sch specific resident and their and treatments. M, ASM #1 (Administrative administrator), ASM #2 (the and ASM #4 (Facility Nurse and ASM #3 (the Assistant provided the line-item accember 2018 through and was no evidence of any not treated with an antibiotic access where we no logs for April 2019 and ASM #3 stated that she at night" based on data left by control nurse, who was no but that there was no data to pril 2019 and May 2019, after control nurse had left. The program (IPCP)" bjectives of this IPCP are to: reference to the prevention, gation, and control of	F	380				
		inistered the medication to						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1			(X3) DATE SURVEY COMPLETED		
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ROVIDER OR SUPPLIER NURSING AND REHA			STREET ADDRESS, CITY, STATE, ZI 730 LUNENBURG HIGHW KEYSVILLE, VA 23947		06/07/2019		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE A CROSS-REFERENCED T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
Resident #41. Resident #41 was ar 7/10/18 with the diag acute respiratory fail pressure, anxiety dis disorder, atrial fibrilla chronic obstructive properties of the depression, and ost MDS (Minimum Data change assessment Reference Date) of coded as being moded make daily life decise coded as requiring the extensive care for the and hygiene; supervusually continent of On 6/04/19 at 4:34 Forepare and administ to Resident #41: Lopressor (1) 12.5 mmg tablet) Calcium (2) 500 mg, Megace (3) 20 mg, Muro (4) 128 solution While preparing the tablet into the medical with her bare fingers pill cutter, cut the pill medication cup. Shocutter before or after 106/05/19, 05:49 PM,	dmitted to the facility on gnoses of but not limited to ure, diabetes, high blood sorder, breast cancer, bladder ation, congestive heart failure, bulmonary disease, eoporosis. The most recent a Set) was a significant with an ARD (Assessment 5/3/19. The resident was erately impaired in ability to ions. The resident was otal care for bathing; ansfers, dressing, toileting, ision for eating; and was bowel and bladder. PM, LPN #2 was observed to ster the following medications are (milligrams) (1/2 of a 25 tablet at tablet in, left eye, 1 drop) Calcium, LPN #2 popped, the ation cup then picked it up and placed the pill into the lain half, and placed it into the ealso did not sanitize the pill rusing it.	F	380				
should have put glov	ves on." When asked if she						
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIENCE REGULATORY OR REGULATORY OR RESIDENT RESIDENT AT THE PROPERTY OF RESIDENT RESIDEN	A95226 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 164 Resident #41. Resident #41. Resident #41 was admitted to the facility on 7/10/18 with the diagnoses of but not limited to acute respiratory failure, diabetes, high blood pressure, anxiety disorder, breast cancer, bladder disorder, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, depression, and osteoporosis. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 5/3/19. The resident was coded as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting, and hygiene; supervision for eating; and was usually continent of bowel and bladder. On 6/04/19 at 4:34 PM, LPN #2 was observed to prepare and administer the following medications to Resident #41: Lopressor (1) 12.5 mg (milligrams) (1/2 of a 25	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 164 Resident #41. Resident #41. Resident #41 was admitted to the facility on 7/10/18 with the diagnoses of but not limited to acute respiratory failure, diabetes, high blood pressure, anxiety disorder, breast cancer, bladder disorder, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, depression, and osteoporosis. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 5/3/19. The resident was coded as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting, and hygiene; supervision for eating; and was usually continent of bowel and bladder. On 6/04/19 at 4:34 PM, LPN #2 was observed to prepare and administer the following medications to Resident #41: Lopressor (1) 12.5 mg (milligrams) (1/2 of a 25 mg tablet) Calcium (2) 500 mg, 1 tablet Megace (3) 20 mg, 1 tablet Muro (4) 128 solution, left eye, 1 drop While preparing the Calcium, LPN #2 popped, the tablet into the medication cup then picked it up with her bare fingers and placed the pill into the pill cutter, cut the pill in half, and placed it into the medication cup. She also did not sanitize the pill cutter before or after using it. 06/05/19, 05:49 PM, in an interview with LPN #2, she stated, "I handled the pill with my hand. I should have put gloves on." When asked if she	ROWDER OR SUPPLIER NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 164 Resident #41. Resident #41. Resident #41 was admitted to the facility on 7/10/18 with the diagnoses of but not limited to acute respiratory failure, diabetes, high blood pressure, anxiety disorder, breast cancer, bladder disorder, atrial fibrillation, congestive heart failure, chronic obstructive pulmonary disease, depression, and osteoporosis. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 5/3/19. The resident was coded as being moderately impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for transfers, dressing, toileting, and hygiene; supervision for eating; and was usually continent of bowel and bladder. On 6/04/19 at 4:34 PM, LPN #2 was observed to prepare and administer the following medications to Resident #41: Lopressor (1) 12.5 mg (milligrams) (1/2 of a 25 mg tablet) Muro (4) 128 solution, left eye, 1 drop While preparing the Calcium, LPN #2 popped, the tablet into the medication cup then picked it up with her bare fingers and placed the pill into the medication cup. She also did not sanitize the pill cutter, cut the pill in half, and placed it into the medication cup. She also did not sanitize the pill cutter cut the pill in half, and placed it into the medication cup. She also did not sanitize the pill cutter cut the pill in half, and placed it into the medication cup. She also did not sanitize the pill cutter cut the pill in half, and placed it into the medication cup. She also did not sanitize the pill cutter to before or after using it. 66/05/19, 05:49 PM, in an interview with LPN #2, she stated, "I handled the pill with my hand. I should have put gloves on." When asked if she	A BUILDING		

1, 7		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
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F 880	#2 stated she did b When asked what s stated that she sho gloves on and pour On 6/6/19 at 7:43 F Staff Member - the Director of Nursing Consultant) were m further information survey. (1) Lopressor - use Information obtaine https://medlineplus.tml (2) Calcium - Calciu foods. The body ne strong bones and to functions. Almost a and teeth, where it hardness. The bod muscles to move at messages between part. In addition, ca vessels move blood help release hormo almost every function Information obtaine https://ods.od.nih.g mer/ (3) Megace - used malnutrition, and se Information obtaine https://ods.od.nih.g	at "I thought silence is golden." she should have done, LPN #2 all have discarded it, put ed another one. PM, ASM #1 (Administrative Administrator), ASM #2 (the and ASM #4 (Facility Nurse hade aware of the findings. No awas provided by the end of the doto treat high blood pressure. It is a mineral found in many eds calcium to maintain or carry out many important and calcium is stored in bones supports their structure and by also needs calcium for and for nerves to carry the brain and every body licium is used to help blood at throughout the body and to anes and enzymes that affect on in the human body. It is treat loss of appetite, evere weight loss.	F 880				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 880	Continued From pag	e 166	F 880				
F 047	ducts/corneal-edema	from om/our-products/dry-eye-pro a/muro-128-ointment	F 04	7	7/04/40		
F 947 SS=C	CFR(s): 483.95(g)(1)	Training for Nurse Aides)-(4)	F 947		7/21/19		
	§483.95(g) Required aides. In-service training m	in-service training for nurse					
	§483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.						
		e dementia management abuse prevention training.					
	determined in nurse and facility assessment	ss areas of weakness as aides' performance reviews ent at § 483.70(e) and may needs of residents as cility staff.					
	to individuals with co address the care of t This REQUIREMEN' by:	rrse aides providing services agnitive impairments, also the cognitively impaired. T is not met as evidenced view and facility document		F-947			
	review, it was detern provide the required	nined the facility staff failed to annual in-service trainings A (certified nursing assistant)		A Staff Development Nurse has been hired by the facility to conduct required service training for Nurses Aides. CNAs who are currently lacking annual documentation of required training will	al		
		d to provide the required 12 three of nine CNAs that		targeted to gain compliance. The Staff Development and training			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCT A. BUILDING				(X3) DATE SURVEY COMPLETED	
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MANANA AND	NUIDONIO AND DELLAD	W 174710N 05N755		7	30 LUNENBURG HIGHW		
WAYLANL	NURSING AND REHAB	ILITATION CENTER		K	KEYSVILLE, VA 23947		
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F 947	Continued From page	e 167	F 9	947			
	were employed for gr CNA #4, and CNA #5	eater than one year, CNA#3,			program will be supervised by the DON her Designee and Administration. Results of the annual training and	l or	
	The findings include:				compliance will be reported to the facility s QAPI Committee for oversight	nt	
	CNAs who were empthan one year was primember) #6, the payremember. A sample of three of relist provided. The annequested at this time. The hire dates of the CNA #3 - 5/16/13 CNA #4 - 2/6/91 CNA #5 - 11/16/96 On 6/5/19 at 4:13 p.m member) #1, the adm documentation. There regarding abuse previous CNA # 3 was the only education. ASM #1 we documentation of the above three CNAs. A				and continued compliance.		
	employed greater that have a staff -developing time. They have gone employees records at twelve hours. The facility policy, "In in part, "C. Monthly In	CNAs that have been in one year. They do not ment staff member at this exthrough the previous and could not locate the inservice policy" documented inservice Programs: Monthly predetermined to meet the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
			7 50.25					
		495226	B. WING			06/	07/2019	
NAME OF PROVIDER OR SUPPLIER WAYLAND NURSING AND REHABILITATION CENTER				73	TREET ADDRESS, CITY, STATE, ZIP CODE 30 LUNENBURG HIGHW EYSVILLE, VA 23947			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)			(X5) COMPLETION DATE	
F 947	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO				